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Community-based Workers Improve Health Outcomes in Uttarakhand, India

The Power of Innovations and Partnership

MARCH 2012

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Community-based Workers Improve Health Outcomes in Uttarakhand, India

END OF PROJECT SYMPOSIUM

The Power of Innovations and Partnership

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FOREWORD

The Accredited Social Health Activist (ASHA), introduced by the Government of India (GoI) in 2005 under the National Rural Health Mission, is the first point of contact for health needs of the rural community in India. These women community health workers are entrusted with the responsibility of promoting healthy behaviors and mobilizing communities to utilize public health services. From the perspective of the shortage of human resources for health in the country, ASHAs are an important resource complementing the health system and facilitating efforts to achieve the Millennium Development Goals.

Effective functioning of ASHAs is challenged through various impediments, including issues of population coverage, competence and motivation. The United States Agency for International Development (USAID) and the GoI through the bilateral Innovations in Family Planning Services (IFPS) Project designed a pilot to improve the effectiveness of the ASHA program in the state of Uttarakhand. The IFPS Project, through the IFPS Technical Assistance Project (ITAP), designed the pilot ASHA Plus project, in consultation with stakeholders at all levels. The ASHA Plus Project focused on expanding access to health care in rural and poor communities through capacity building of the ASHA Plus workers, introducing flexible population coverage and performance-based remuneration to enhance community acceptance. Encouraged with the success of the pilot program, the Government of Uttarakhand introduced an ASHA Support System to strengthen the ASHA Plus program and scaled up the program to the entire state.

This report is an insight into the journey of the ASHA Plus program developed and demonstrated through a public private partnership approach involving local non-governmental organizations. It demonstrates how flexibility and senstivity to the local context can address region-specific challenges and provide solutions which are locally relevant. I am thankful to ITAP for compiling this end of project report. USAID hopes it will provide useful insights to strengthen the effectiveness of ASHA workers across the country.

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ACKNOWLEDGMENTS

This report documents the accredited social health activist (ASHA) Plus project and ASHA Support System through NGO partnerships, a public private partnership (PPP) initiated in Uttarakhand to improve the effectiveness of the National ASHA Program in Uttarakhand. Several PPP initiatives have been undertaken as part of the Innovations in Family Planning Services (IFPS) project in Uttarakhand, Uttar Pradesh and Jharkhand. The IFPS Technical Assistance Project (ITAP), implemented by Futures Group International, India in partnership with Bearing Point, Sibley International, Johns Hopkins University, and QED, provides technical assistance to the IFPS project. The USAID funded IFPS project is a joint US-India initiative that has worked to promote improved FP/RH for India's poor communities and works in close collaboration with Ministry of Health and Family Welfare, Government of India (GoI) as well as with state societies in Uttarakhand, Uttar Pradesh and Jharkhand.

Importantly, this report highlights the achievements of numerous state and district partners who played an integral role in the design and implementation of the ASHA Plus program and ASHA Support System. Key partners include the Government of Uttarakhand, Uttarakhand Health and Family Welfare Society (UKHFWS), local NGOs and ASHA Supervisors, ASHA Plus workers, and ASHAs. The contribution of Vikalp design, Udaipur is acknowledged for supporting the capacity building efforts.

The project wishes to acknowledge the technical leadership and guidance provided by the USAID India Mission over years of implementation of the ASHA Plus project, especially Monique Mosolf, Sheena Chhabra, Dr. Loveleen Johri, Jyoti Shankar Tewari, Shweta Verma, Vijay Paulraj and Moni Sinha Sagar.

Elizabeth Leahy Madsen and Shuvi Sharma, Futures Group, compiled this report, drawing on a range of published reports, unpublished project reports and databases, peer reviewed and grey literature, and interviews with project staff, partners, program staff nongovernmental organizations (NGOs) and community workers (ASHAs). Several individuals and an organization contributed to the compilation, drafting and review of this report, including Dr. Suneeta Sharma, Dr. Gadde Narayana, Dr. A A Jayachandran, Tanya Liberhan, Rajiv Ranjan, Dr. Utpal Das, Ashutosh Kandwal, Abhishek Dixit, Ashish K Mishra, Meenakshi Dixit, Lippi Doshi and New Concept Information Systems. This report also draws on previous project documentation efforts by the ITAP team which proved to be invaluable.

ABBREVIATIONS

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
CBD	Community-Based Distribution
CHC	Community Health Center
CHW	Community Health Worker
CMO	Chief Medical Officer
DARC	District ASHA Resource Center
DLHS	District-Level Household Survey
DOTS	Directly Observed Therapy, Short-Course
DPMU	District Program Management Unit
ECP	Emergency Contraceptive Pill
ELCO	Eligible Couple
FP	Family Planning
GoI	Government of India
GoUK	Government of Uttarakhand
HIHT	Himalayan Institute Hospital Trust HIHT
HIMAD	Himalayan Society for Alternative Development
HIV	Human Immunodeficiency Virus
IEC	Information, Education, and Communication
IFA	Iron and Folic Acid
IFPS	Innovations in Family Planning Services
IMR	Infant Mortality Rate
IPC	Interpersonal Communication
ITAP	IFPS Technical Assistance Project
IUCD	Intrauterine Contraceptive Device
JANDESH	Jai Nanda Devi Swarozgar Shikshan Sansthan
JSY	Janani Suraksha Yojana
KAGAS	Kumaon Agriculture and Greenery Advancement Society
LHV	Lady Health Visitor

MIS	Management Information System(s)
MNGO	Mother Nongovernmental Organization
MOIC	Medical Officer in-Charge
NGO	Nongovernmental Organization
NRHM	National Rural Health Mission
OCP	Oral Contraceptive Pill
OPEN	Organization for Prosperity, Education and Nurture
PHC	Primary Health Center
PNC	Postnatal Care
PPP	Public-Private Partnership
PRI	Panchayati Raj Institution
RCH	Reproductive and Child Health
RH	Reproductive Health
SARC	State ASHA Resource Center
SHSRC	State Health Systems Resource Center
SIFPSA	State Innovations in Family Planning Services Agency
SPMU	State Program Management Unit
STEM	Centre for Symbiosis of Technology, Environment and Management
TAG	Technical Advisory Group
ToT	Training of Trainers
UKHFWS	Uttarakhand Health and Family Welfare Society
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

In 2005, as a key component of efforts to expand access to health services in underserved areas, India's National Rural Health Mission (NRHM) introduced the accredited social health activist (ASHA), a community health worker (CHW). ASHAs are intended to be the linchpin of a strategy to mobilize communities to adopt healthy behaviors and utilize public health services. They are first point of contact in the community and they complement the efforts of other health workers.

Selected from the village itself and accountable to it, ASHAs are trained to serve as an interface between the community and the public health system. According to the NRHM guidelines, one ASHA should be in place for every 1,000 village population. ASHAs are not paid a fixed salary under NRHM but they receive performance-based remuneration as motivation.

In Uttarakhand, as in other states, ASHAs were introduced under NRHM to promote healthy behaviors amongst the communities. However, feedback from communities and ASHAs themselves made it quickly apparent that they faced challenges in providing uniform services to the population due to the state's hilly terrain, with small and scattered settlements covering a large geographical area, as well as poor road connectivity and limited modes of public transport. These geographical challenges left ASHAs in Uttarakhand unable to sustain themselves on the earnings they made because they were covering a smaller number of people than intended.

The Government of Uttarakhand (GoUK) asked the United States Agency for International Development (USAID) as part of the Innovations in Family Planning Services (IFPS) project to design a pilot project to improve the effectiveness of the ASHA program. After consulting with stakeholders at the state, district, and block levels, and assessing local conditions, the Innovations in Family Planning Services Technical Assistance Project (ITAP) designed the ASHA Plus program. The program was piloted by the Uttarakhand Health and Family Welfare Society (UKHFWS) for two years, beginning in January 2007 in two blocks in each of the three upper Himalayan districts of the state, Chamoli, Uttarkashi, and Pithoragarh. The pilot was implemented under a public-private partnership (PPP) mechanism, engaging nongovernmental organizations (NGOs) to lead the selection, training, mentoring, and support of the ASHA Plus workers. ITAP helped to select the project intervention areas and NGOs, and supported the NGOs' activities.

To achieve its goal of improving access to a wide range of health services among the poor in Uttarakhand, the ASHA Plus program introduced flexible population coverage for the ASHA Plus workers and rendered remuneration for an increased number of services. The ASHA Plus workers were selected by the field NGOs, which also involved the community in the process.

Training was an important aspect of the ASHA Plus program. ITAP modified Government of India (GoI) training modules for ASHAs to develop more interactive training material for the new cadre of workers. Participatory training methodologies were used, and ASHA Plus workers were given job aids to facilitate interpersonal communication (IPC) with target groups on various health issues. In addition, several new topics were introduced and taught to ASHAs to make their work more effective, such as micro planning tools and management information systems. ASHA Plus workers received 23 days of residential training in four phases conducted over 12 months, during which a total of 570 ASHA Plus workers and 41 ASHA Plus supervisors were trained. ITAP provided technical assistance in training the ASHA Plus workers and NGOs, and was involved in monitoring and reviewing the program.

The ASHA Plus workers helped to spread awareness on a range of health issues. They disseminated information on health issues and government programs, mobilized

villagers to adopt healthy behaviors, and held monthly meetings with the community. They worked in tandem with other community level workers to strengthen linkages between government health systems and households. Special job aids were developed, pre-tested and adapted for ASHA Plus workers which helped them better communicate with beneficiaries. An ASHA diary was also developed and used by the ASHAs to make notes and record information, and details collected during household visits. With slight modifications and new formats, these tools are now used by the Department of Health and Family Welfare, GoUK.

A rapid assessment conducted in the blocks where ASHA Plus workers were active, revealed that they were well equipped with technical information and skills to mobilize communities to utilize health services. Learning from the pilot program's reach, success, and adaptability, the GoUK decided to strengthen the ASHA Plus program and introduced an ASHA support system, reaching from the village to the state level. This included the establishment of the State ASHA Resource Center (SARC), State ASHA Mentoring Group, and District ASHA Resource Centers (DARCs) in 2008-09. The SARC is the technical agency that provides inputs and supportive mechanisms to the ASHAs under NRHM, while the DARCs were established with the purpose of mentoring and providing technical support and training to ASHAs.

The assessment also revealed improvement in health indicators in the ASHA Plus program intervention areas, which encouraged the state government to scale-up the program across six districts. The GoUK strengthened the SARC and DARCs in six districts in the form of additional human resource support and further by building their capacities. Technical inputs for scale up were provided by ITAP.

The ASHA Plus program ended in March 2009, but on the basis of its success and a few modifications in the existing ASHA program, the program has been scaled- up across the state of Uttarakhand by UKHFWS. The total population covered has increased from about 0.26 million people in the six blocks of the pilot stage to 3.13 million across six districts. Technical support similar to that provided by ITAP is now managed by an NGO contracted to serve as the SARC. The DARCs have been further expanded to support NRHM's ASHA program in all 13 districts of Uttarakhand, similar to ASHA Plus NGOs at the block level. (ITAP 2006; MIS ITAP compiled from October 2007- September 2008)

The NRHM's ASHA program made significant contributions to expanding access to healthcare in rural and poor communities across India but needed to be modified and tailored to the special context of Uttarakhand to maximize its impact. The partnership between the GoUK, local NGOs, and ITAP through the IFPS project demonstrated that adaptability and flexibility to the local context can produce more effective outreach and significantly improve health outcomes. Moreover, the ASHA Plus program enhanced community acceptance and mobilization of health services, while offering stronger training and support to CHWs.

Chapter 1

INTRODUCTION

Poor people living in sparsely populated areas of developing nations with limited infrastructure and access to health services often compromise on the investment they make in health. Shortage of skilled health workers contributes to the problem of limited infrastructure and access, particularly in underserved areas. The World Health Report (2006) focuses the world's attention on human resources as the key ingredient to successful health systems functioning, and it highlights the growing human resource crisis, particularly in low-income countries. These shortages are driven by many factors, including inadequately funded, poorly managed and poorly performing health systems, which leads to deteriorating working conditions in many underserved areas. One strategy identified by governments around the world is "task shifting"—a review and subsequent delegation of tasks to the "lowest" category that can perform them successfully. It is in the context of task shifting that the concept of using community members to render certain basic health services to their communities has gained currency again (Joint Learning Initiative, 2004; World Health Report, 2006; and Lehmann and Sanders, 2007).

Around the world, community health workers (CHWs) have different names and provide somewhat different services, but they share a common purpose. The World Health Organization (WHO) has outlined the following definition of CHWs: "Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers" (Lehmann and Sanders, 2007). While their responsibilities vary from setting to setting, CHWs have been on the frontlines of expanding the reach of the health system by connecting it to people where they live.

Experience of working with CHWs in India in the past has been limited to small areas (see Section 2). It was in 2005 that the Government of India (GoI) introduced a new cadre of CHWs, known as accredited social health activists (ASHAs), at the national level as an architectural reform to health systems. Thousands of female health workers were selected from communities, trained in basic healthcare, and provided performance-based remuneration for health services accessed by members of their community. At the time of introduction, the GoI provided detailed guidelines for the selection of ASHAs, their coverage area, working arrangements, roles and responsibilities, remuneration, and financing mechanisms. It was for the states to adapt these guidelines according to their local conditions. In Uttarakhand, feedback from the community and the ASHAs suggested that they faced challenges in providing services to a uniform population (one ASHA per 1,000 population, as per NRHM guidelines), mainly due to the hilly terrain with small and scattered settlements covering a large geographical area, as well as poor road connectivity with limited modes of public transport.

To respond to this challenge, the Government of Uttarakhand (GoUK) asked the Innovations in Family Planning Services (IFPS) Technical Assistance Project (ITAP), funded by the United States Agency for International Development (USAID), to design a pilot intervention to enhance the effectiveness of the ASHA program in the remote and hilly regions of the state.

1.1 PURPOSE AND ORGANIZATION OF THE REPORT

This report captures the genesis and implementation of the ASHA Plus project in the context of Uttarakhand. As an end of project report, it is intended to highlight the best practices, lessons learned, and recommendations developed over the course of IFPS and ITAP's work on the ASHA Plus program. It is hoped that these experiences will offer guidelines for future CHW initiatives in India and around the world.

Section 2 provides contextual background in a brief summary of previous CHW programs in India. Section 3 presents the rationale behind the ASHA Plus project and why ASHAs have a special role in the hilly, difficult-to-reach Uttarakhand region. Section 4 details the strategy, design, and implementation of the pilot project and discusses the findings of the rapid assessment. In Section 5, the recent scale-up of the project is reviewed, including the leadership and commitment provided by the GoUK. Section 6 summarizes the main achievements and lessons learned. Section 7 discusses the scale up of the model in Uttarakhand and the report concludes with Section 8 discussing the way forward for the program.

Chapter 2

COMMUNITY HEALTH WORKERS IN INDIA

In India, CHWs have existed since 1977. The names of workers and the scheme changed over time; from CHW in 1977 to Community Health Volunteer in 1980 and (male) Village Health Guides in 1981. The Village Health Guides scheme was centrally sponsored untill April 2002. Due to sustainability issues it was suggested that states mobilize resources for continuing the scheme, after which the scheme was largely discontinued (UNICEF, 2004). Evidence shows that the CHWs can be extremely effective to work as a complimentary force promoting utilization of available health services and the link between community and health system. They have improved health outcomes by using interpersonal communication (IPC) and behavior change communication (BCC) strategies to raise awareness and improve health seeking behavior. CHWs distribute simple essential health commodities beyond fixed facilities and outlets thereby expanding the coverage of healthcare.

Internationally, as in India, experiences indicate that no one model is perfect and works in all contexts (UNICEF, 2004). Nongovernmental organizations (NGOs) have been administering CHW programs in the country based on their local needs. The Comprehensive Rural Health Project model in Jamkhed pioneered the female village health worker concept in Maharashtra, providing training to barely literate women with the aim of improving maternal and child health status in their communities. This served as a major inspiration to similar programs that were initiated by the Rural Unit for Health and Social Affairs in Vellore, Tamil Nadu; Foundation for Research in Community Health in Mandwa, Raigad district of Maharashtra; Self-Employed Women's Association in rural Gujarat; Sanjeevani in Haryana; and Search of Health Care for Rural and Tribal People in Gadchiroli, Maharashtra. More recently, the *Mitanin* female health worker program in Chhattisgarh pioneered several best practices, including "a collaborative effort between the state, NGOs, and funders," the establishment of "supportive institutional mechanisms," and in-depth training with refreshers. However, the *Mitanin* experience also highlighted several challenges, including inconsistent remuneration, lack of community engagement in selection of the workers, low knowledge levels, and limited collaboration with other health workers such as auxiliary nurse

A CHW greets a young mother and her child

midwives (ANMs) (Lehmann and Sanders, 2007; and Bajpai and Dholakia, 2011).

A successful model was adopted by IFPS to engage community-level NGOs in Uttar Pradesh to reach underserved populations with information and services on family planning (FP) and reproductive health (RH). This was done through community-based distribution (CBD) workers and community health visitors, who were hired and supervised by local NGOs, in coordination with medical facilities, local government health authorities, and existing village institutions such as *Panchayats*[1]. The CBD workers were mostly women living in villages or slum areas who received a set monthly remuneration of Rs. 600 (USD12). They educated and counseled clients on FP, distributed contraceptives, enrolled pregnant women for antenatal care (ANC) and children for immunization, referred clients for intrauterine contraceptive devices (IUCDs) and sterilization services in coordination with ANMs, organized communication activities and group meetings, and encouraged support from local opinion leaders. The community health visitors fulfilled the role of ANMs in cases of vacancy or absence, and provided higher levels of ANC and postnatal care (PNC), IUCD insertion and removal, and immunizations. After three years, the contraceptive prevalence rate in the program area increased from 23 to 36 percent (Constella Futures, 2006).

[1] The village panchayats are the basic village level unit of the decentralized system of governance in India

Chapter 3

RATIONALE FOR ASHA PLUS PROGRAM

3.1 REPRODUCTIVE HEALTH SCENARIO IN UTTARAKHAND IN 2005

Uttarakhand, previously known as Uttaranchal, became India's 27th state in 2000 when it was carved out of the adjoining state of Uttar Pradesh. The state is distinguished by its hilly terrain, particularly in the Himalayan foothills and mountains. According to Census 2001, Uttarakhand had a population of 8.5 million. At the time, the state had 13 districts, including 16,836 villages, with about 74 percent of the population of the state living in rural areas. About 36 percent of the state's population was younger than 15 years of age and only five percent was age 65 or above. The overall literacy rate was high at 60 percent (Census 2001). The state, being a hilly one, is the most sparsely populated state in the country, with a population density of 159 persons per sq. km. The poor road connectivity, difficult hilly terrain (86% of area is in hills), small scattered settlements, and lack of adequate infrastructure and transport facilities contribute to limited access to health service delivery (Directorate of Economics and Statistics, GoUK 2011)[2]. Given the poor paying capacity, scattered location of settlements in hilly districts, and lack of private providers, the population is largely dependent on the public health delivery system.

In 2005, the RH indicators in Uttarakhand directed differentials between urban and rural populations as well as hill and foot-hill districts. The decadal population growth rate for the state from 1991–2001 was 19.2 percent, compared with the 24.2 percent recorded for 1981–1991, a decline of five percentage points (Census 2001). The estimated crude birth rate for Uttarakhand in 2005, as per the Sample Registration System (SRS), was 20.9 births per 1,000 population. The birth rate for rural and urban Uttarakhand was 22.1 and 16.6, respectively. The natural growth rate during the same period in Uttarakhand was 13.6, percent, compared with the national average of 16.3 percent. The infant mortality rate (IMR) in Uttarakhand (42) was also significantly lower than that of the India average (58). There were significant differences in the IMR in urban (19) and rural areas (56). In general, the hill districts had lower birth rates, total fertility rates, and IMRs compared with the districts located in the foot-hills (SRS, 2006).

More than 44 percent of currently married women in the reproductive age group used modern contraceptive methods, and only 17 percent of the couples used modern spacing methods (DLHS-2, 2002–2004). The number of pregnant women availing ANC services was low in Uttarakhand. Nearly 63 percent of the pregnant women received any ANC and only 28 percent visited for three or more ANC check-ups. Nearly 24 percent of the women delivered babies at home. Only one out of seven births (14%) that occurred outside a medical facility received a postpartum check-up within two months of delivery (DLHS-2, 2002–2004).

Almost one-third (30%) of the women in Uttarakhand were classified as "total thin" as per the body mass index (< 18.5) (NFHS-3, 2005–06). Low birth weight was an important cause of concern in Uttarakhand, as about 32 percent of the children below three years of age were underweight (NFHS-3, 2005–06).

3.2 ASHA PROGRAM

In 2005, the GoI launched the National Rural Health Mission (NRHM) to provide universal access to equitable, affordable, and high-quality healthcare in 18 "high-focus" states, including Uttarakhand. Recognizing the potential of CHWs in helping state governments achieve health goals, the NRHM introduced ASHAs to promote healthy behaviors and mobilize communities to utilize public health services. ASHAs were positioned as a first point of contact for the health needs of communities

[2] For further information refer http://uk.gov.in/pages/display/116-at-a-glance

and were to be complementary to health workers who were already working in the field, specifically ANMs, male multipurpose workers, and anganwadi workers (AWWs)[3].

Uttarakhand initiated the selection of ASHAs in 2005. Given the challenges of the health system and the population it serves, the cadre of ASHAs has significant relevance in states like Uttarakhand. Drawn from the community, ASHAs understand the issues that commonly affect health status and behavior. With training and capacity building, they can be effective "ambassadors" for health, helping improve maternal and infant mortality, increasing the rate of institutional delivery, and addressing anemia, malnutrition, and sanitation. They can complement the existing healthcare system and be valuable partners of the state government, playing a key role in the chain of development.

However, as the program was rolled out in Uttarakhand, feedback from communities and ASHA workers highlighted the challenges they face in accessing and providing services.

In spite of NRHM assigning special importance to hilly areas like those in Uttarakhand, the ASHA program's success was compromised due to physical impediments. With more than 93 percent of the land mass consumed by hills, of which 70 percent is forest, along with poor transport connectivity and institutional deficiencies, ASHAs were unable to expand access to health service delivery at the village level to the extent that had been planned. The ASHA Plus program was thus initiated to meet the need for a locally relevant designed CHW program.

[3] An AWW is a community level worker providing child health and nutrition services as part of the Integrated Child Development Services Program of the Ministry of Women and Child Development, Government of India.

Chapter 4

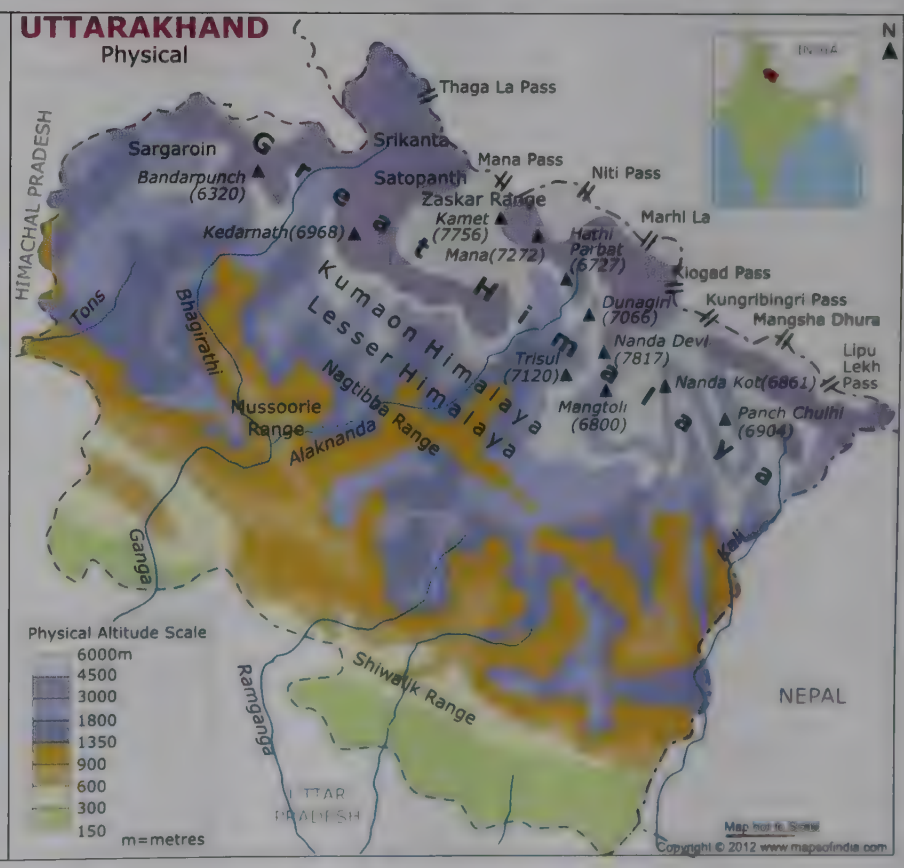
PILOT DESIGN, IMPLEMENTATION, AND ASSESSMENT

The GoUK quickly responded to these implementation challenges by deciding to adapt and strengthen the existing ASHA program. The government proposed a pilot project for the USAID supported IFPS Project to implement from January 2007–March 2009.

The first step in conceiving the revised ASHA program in Uttarakhand was to design a pilot project through stakeholder consultation and an assessment of on ground issues. Three districts (Chamoli, Pithoragarh, and Uttarkashi) were selected due to their location in the Upper Himalayas (Figure 1), which presents the most geographic challenges to health service delivery. Within each district, two blocks were selected (Bhatwari and Purola in Uttarkashi; Joshimath and Karnaprayagin Chamoli; and Munsiyari and Munakot (previously known as Bhadalu) in Pithoragarh) for intervention. The six blocks were selected because they are among the most difficult to reach and sparsely populated.

After doing the needs assessment, in 2006, a block level baseline survey was conducted in the six implementation blocks. A total sample size of 6,876 households was taken for the baseline survey. The tools designed for the survey included three questionnaires: a household questionnaire, a woman questionnaire

FIGURE 1: POLITICAL MAP OF UTTARAKHAND **FIGURE 2: PHYSICAL MAP OF UTTARAKHAND**



Source: http:\\www.mapsofindia.com

and a child questionnaire. The survey was designed to provide estimates for key parameters (utilization of health facilities, fertility, FP, ANC, delivery care, child health care practices etc.) in the project intervention blocks.

Consultative meetings were held in July 2006 with district and block officials, health workers, NGOs, Panchayati Raj Institution (PRI) representatives, and community members. At the end of the meetings, there was consensus on the need to modify the ASHA program in each district. Participants in the meeting also discussed the tentative roles and responsibilities of the workers, selection criteria, compensation, and financing arrangements.

The district level meetings were followed by a state level consultation with state and district health officials, district program managers and NGOs from Uttarkashi, Chamoli, and Pithoragarh in August 2006. Discussions revolved around the experience of civil society in implementing community-based volunteer programs and outcomes of the stakeholder meetings in the selected blocks. The selection criteria, monitoring systems, finance mechanisms, and management for the pilot ASHA Plus program were finalized during this consultation.

4.1 PUBLIC-PRIVATE PARTNERSHIP APPROACH TO ASHA PLUS

The ASHA Plus project was designed as a model for increasing community participation and enabling community action for accessing health services in remote areas. The project was designed to develop strong linkages between the community and health systems through a public-private partnership (PPP) model. During the consultations to design the model, it was recognized that monitoring the implementation of ASHA Plus program in addition to regular training and mentoring of ASHA Plus workers would be difficult for the Uttarakhand Health and Family Welfare Society (UKHFWS). Therefore, management of the initiative by local NGOs or civil society institutions was considered. The UKHFWS partnered with four NGOs to implement the project, with a focus on providing FP, reproductive and child health (RCH), and other services.

Project Goal

To develop an evidence-based model for implementation of the ASHA scheme to meet state specific requirements of Uttarakhand

The complementary roles of all partners in this PPP model, namely, UKHFWS, ITAP, NGOs, and ASHA Plus workers were delineated right from inception. The UKHFWS oversaw the financial flows and overall monitoring. ITAP conceptualized and designed the program through stakeholder consultation, selected the intervention areas, supported UKHFWS in selection of the implementing NGOs, provided technical assistance for training and mentoring of NGO workers, monitored and reviewed the program, and offered technical inputs during scale-up. The NGOs recruited, trained, and supervised the ASHA Plus workers, and coordinated with both communities and the UKHFWS. Block Coordinators were also hired by NGOs to provide overall supervision and monitoring of the ASHA Plus workers. In addition to the ASHA Plus workers, other health workers also played an important role. Existing ANMs provided a link between health facilities and communities, and cooperated with the ASHA Plus workers for improved service delivery. Figure 2 details these roles.

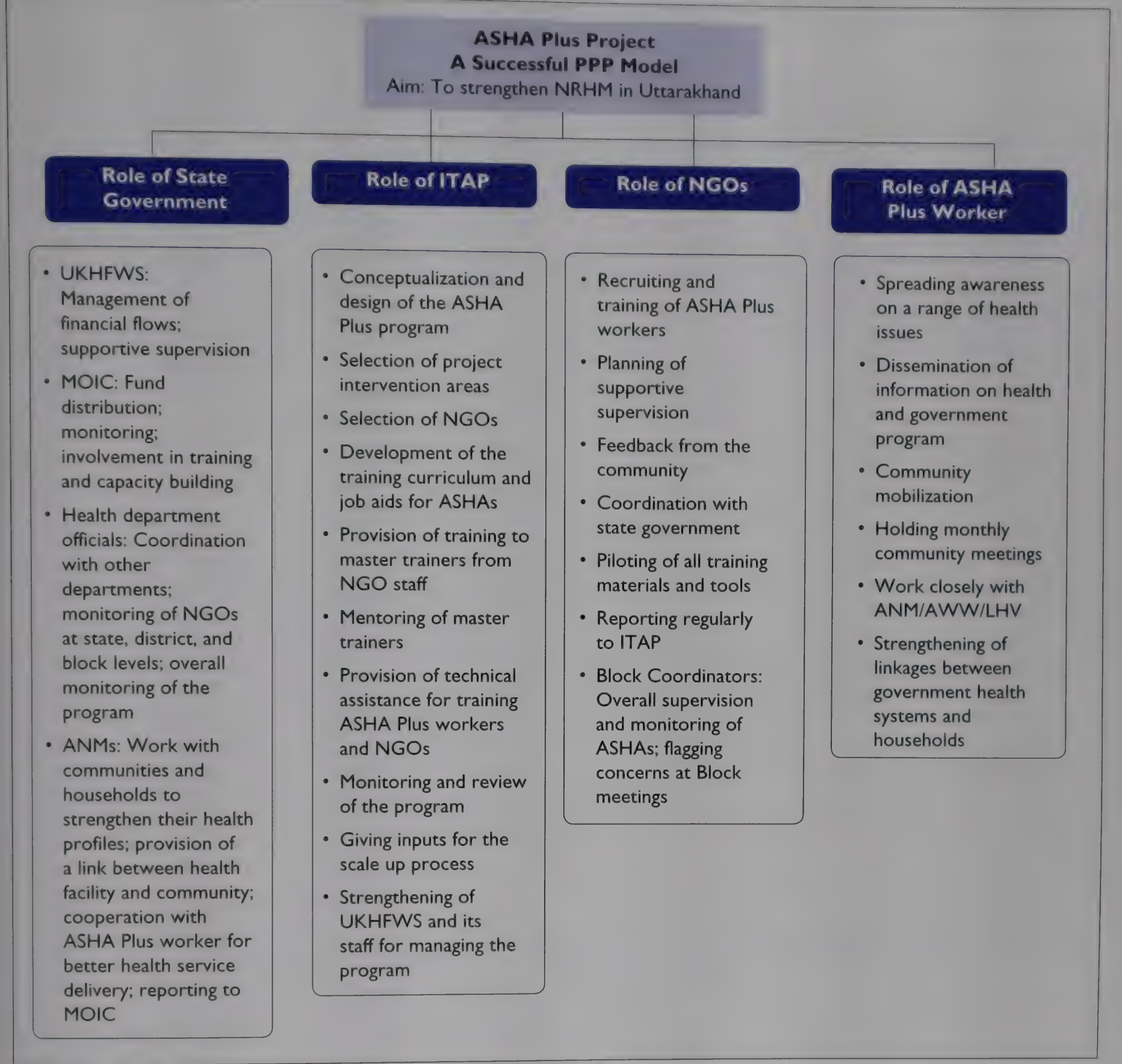
4.2 NGO SELECTION AND TEAM COMPOSITION

After the intervention areas had been selected through stakeholder consultation, ITAP supported UKHFWS in selecting the partner NGOs. A request for proposal was sent to a group of shortlisted NGOs eligible to be implementing partners for the ASHA Plus program. Potential partner NGOs were identified on the basis of their entrenchment within the community as well as their credibility and reputation.

When selecting NGOs, the team considered their experience and competence in social interventions and social research, preferably related to RCH program implementation, and their knowledge of the health sector, especially NRHM and GoI's RCH-II program. NGOs were also required to have working knowledge of cross-cutting disciplines, including institutional development, health economics, and social development with a gender equitable and pro-poor approach; experience working with government at the macro and micro levels; institutional and financial capacity to manage their work in a timely and efficient manner; and sound communication and documentation skills. Preference was given to NGOs with a self-help group or team of community volunteers.

The NGOs selected for the project districts were as follows:

FIGURE 3: ROLES OF PUBLIC-PRIVATE PARTNERS IN ASHA PLUS PROGRAM



- Purola and Bhatwari blocks, Uttarkashi District: Organization for Prosperity, Education and Nurture (OPEN)
- Joshimath Block, Chamoli District: Jai Nanda Devi Swarozgar Shikshan Sansthan (JANDESH)
- Karnaprayag Block, Chamoli District: Himalayan Society for Alternative Development (HIMAD)
- Munakot and Munsiyari blocks, Pithoragarh District: Kumaon Agriculture and Greenery Advancement Society (KAGAS)

Each NGO established a project team, including a project manager, block coordinators, field supervisors cum master trainers, and an administration and accounts officer. Within their designated block(s), each NGO was responsible for

TABLE 1: ROLES AND RESPONSIBILITIES OF NGO STAFF

Field Supervisors	Block Coordinators	Project Managers
Prepare micro plan for visiting each village in their cluster once every two months	Participate as trainers in the training	Ensure implementation of activities as per the work plan
Attend monthly Primary Health Center (PHC) meeting of ASHA Plus workers and ANMs	Forward progress reports (programmatic and financial) after review	Supervise functioning of all staff
Facilitate activities of the Village Health and Sanitation Committee	Supervise functioning of supervisors and prepare micro plan for field visits	Prepare and send progress reports (programmatic and financial) after review
Make joint visits with ASHA to houses of "at risk cases"	Attend cluster meetings	Liaise with government personnel to ensure effective program implementation
Organize community meetings at the village level	Make at least one field visit every two months to villages to supervise activities of ASHA Plus workers and supervisors	Make field visits to monitor activities
Liaise with stakeholders at the village level	Liaise with government personnel to ensure effective program implementation	
Facilitate social marketing of health products through training of ASHAs, conduct community meetings at the village level, maintaining records	Organize regular coordination meetings with government personnel	
Disseminate monthly information to other village stakeholders	Ensure the implementation of block-level trainings of ASHAs on social marketing	

selecting ASHA Plus workers, building their capacity through four training phases, mentoring and supervision, distributing performance-based reimbursements after due assessment, and establishing management information systems (MIS).

Once selected, the NGOs were sensitized and trained on a set of benchmarks to ensure smooth implementation of the pilot project.

The four NGOs were a strong support system for the ASHA Plus workers. Regular meetings between the NGO and the worker provided a platform for technical discussions as well as for identifying and addressing problems the ASHA Plus worker may be facing in the field. This two–way communication approach worked well to keep the ASHA Plus workers motivated and perform efficiently.

4.3 SELECTION OF ASHA PLUS WORKERS

The ASHA Plus workers, who were all women, were recruited by the NGOs working in their communities in accordance with criteria finalized during the consultation. Selection occurred in an open village/ community forum in consultation with the village *Panchayat*, ANMs, and/or AWWs; members of the *mahila mangal dal* (women's groups); and school teachers. In cases where two or more candidates were identified, the selection was completed by casting votes.

During the stakeholder consultation and project design, several selection criteria were established for the ASHA Plus workers. Each worker was required to have completed Class VIII or beyond; reside in the village where she would work; be a married or single woman who is divorced, widowed, or does not wish to marry; and be acceptable to the community as determined in the open forum.

The first step in selection of the ASHA Plus workers was for the local NGO to meet *Panchayat* members as well as the community and share the ASHA Plus model with them.

ASHA Plus workers in a village in Uttarakhand

BOX 1: FLEXIBLE SELECTION CRITERIA FOR NEEYAJAN

Many villages insisted on having their trusted *dais* (traditional birth attendants) as ASHA Plus workers, even if they did not conform to the selection criteria. In one village, Neeyajan, a *dai* (traditional birth attendant), insisted on being an ASHA Plus worker. She was 47 years old and illiterate. After detailed discussions with the community and *Panchayat*, the NGO working in that area agreed to retain and train her. Her daughter-in-law, who had studied until Class X, was asked to maintain all records. After a few months in the program, Neeyajan had emerged as one of the most results-oriented ASHA Plus workers, setting her own targets and achieving them consistently. She was well regarded in the community and could succeed in motivating her neighbors to make sound health decisions, such as choosing an institutional delivery.

Next, the village-level *Panchayat* met with the community to select the ASHA Plus worker, who was selected through community consensus. More than 570 ASHA Plus workers were designated, attended training, and began their community work during the project.

4.4 ASHA PLUS WORKERS: ROLE AND RESPONSIBILITIES

The ASHA Plus workers were tasked with several responsibilities, many of which were different than those of ASHAs working under the NRHM, in order to account for the unique context in remote regions of Uttarakhand, as shown in Table 2. For example, the ASHA Plus workers utilized MIS and household mapping for micro planning. The structure of the program also differed from NRHM's ASHA model in several ways.

ASHA Plus workers were expected to have regular interaction with the community to spread awareness and information about health services and service delivery points for ANC, PNC, institutional delivery, child health, FP, and benefits like the *Janani Suraksha*

TABLE 2: COMPARISON OF ASHAs AND ASHA PLUS WORKERS

ASHAs under NRHM	ASHAs under the ASHA Plus Program
Uniform population coverage	Flexible population coverage
Selection by health department and *Panchayats*	Selection by NGO, health department, and *Panchayats*
Training material developed by health department	Training material developed by training experts based on GoI modules
Lecture-based training programs conducted by the health department, with no skills building	Interactive training programs, including sessions for skills building conducted by NGOs and professional trainers
No job aids given	Job aids provided for communication
Performance-based disbursement for limited services	Performance-based disbursement system for a wide range of services
Inflexible systems for financing	Flexible system for financing
MIS not yet developed	MIS developed and introduced
No micro-planning	Household and eligible couple (ELCO) mapping for micro planning

An ASHA Plus worker interacts with the community to spread awareness on healthy behaviors

Yojna (JSY).[4] ASHA Plus workers also mobilized the community to maintain hygiene and sanitation, for example by promoting household toilets.

ASHAs working under the NRHM were expected to cover 80–300 households. The number of households assigned to each ASHA Plus worker was generally smaller, ranging from 70 to 150, allowing the ASHA Plus workers to devote more time to individual community members. The program implemented a concept of flexible population coverage for each ASHA Plus worker, based on the local population density and not exceeding a radius of two kilometers from their home village. Considering the difficult geographic terrain of the state and scattered and inaccessible population groups, the concept of flexible population coverage depending on geographic accessibility was key to ensuring that the ASHA Plus workers were able to fully implement services in their designated population.

The ASHA Plus workers were required to hold monthly community meetings to discuss various health issues such as ANC and PNC, complications during pregnancy, nutrition and diet, child care, immunization, FP, and more. Their interactions with the community went beyond the health portfolio to include hygiene, sanitation, and social issues.

The ASHA Plus program focused on coverage of a wide range of health issues, including all aspects of immunization, institutional delivery, and FP methods. There was equal focus on early registration of pregnancy, the importance of three ANC check-ups and multiple PNC visits, and follow-up for subsequent services. As shown in Table 3, while the NRHM and ASHA Plus programs offered equal remuneration for certain services, such as institutional delivery and immunization, the ASHA Plus program offered remuneration for a much larger number of services, ranging from Rs. 5 (USD 0.1) to Rs. 600 (USD12). This expanded basket of services provided ASHA Plus workers with additional avenues for income generation. This was an important design modification to ensure that the ASHA Plus workers income would not be affected by a reduction in population coverage.

4.5 TRAINING, CAPACITY BUILDING, AND POSITIONING OF ASHA PLUS WORKERS

During the pilot program, 570 ASHA Plus workers and 41 supervisors were provided 25 days residential training in four phases over 12 months.

Training curriculum: The training curriculum specially developed for Uttarakhand was based on GoI NRHM modules, used the life cycle approach, and included sections on life skills education. The ASHA guide of NRHM recommended eight tasks for ASHA workers which were divided into five essential areas: (1) knowledge about and planning for the village; (2) technical information on the NRHM, FP/RH, and linkages using the life cycle approach; (3) BCC, with an emphasis on life skills education; (4) depot and record keeping; and (5) referral and first aid.

Media Material: To supplement their training and as a mechanism for ongoing support, special job aids were developed for ASHA Plus workers to help them communicate with beneficiaries. Utilized across the four phases of training, the aids reviewed workers' roles and responsibilities and those of the

[4] A conditional cash transfer program introduced by GoI, in which pregnant BPL women who avail at least three ANC visits and have an institutional delivery in a public sector facility receive a specified amount of money.

TABLE 3: COMPARISON OF REMUNERATION FOR ASHAs AND ASHA PLUS WORKERS

Service	ASHA Plus Suggested Remuneration/Case (in Rs.)	NRHM Remuneration/Case (in Rs.)
Early registration	20/- (USD 0.4)	-
Completion of 3 ANC checkups	50/- (USD 1)	-
2 TT injections	25/- (USD 0.5)	-
Adequate IFA to pregnant women	50/- (USD 1)	-
Institutional deliveries referred	600/- (USD 12)	600/- (USD 12)
Registration of births	20/- (USD 0.4)	-
Early initiation of breast milk	50/- (USD 1)	-
Complete immunization of a child	150/- (USD 3)	150/- (USD 3)
Male sterilization	250/- (USD 5)	250/- (USD 5)
Female sterilization	150/- (USD 3)	150/- (USD 3)
Iron supplementation	5/- (USD 0.1) per consumption of 100 tablets	-
Deworming	5/- (USD 0.1) per dose	-
Number of referrals generated	5/- (USD 0.1) per referral	
DOTS treatment completed	250/- (USD 5)	250/- (USD 5)
Dressing of wound	5/- (USD 0.1) per dressing	-
Household toilet promotion	50/- (USD 1)	50/- (USD 1)

Source: Official notification from Additional Director, National Program, Directorate of Medical and Family Welfare, Uttarakhand to the Chief Medical Officer, Uttarakhand, dated February 12, 2008.

Minutes of the TAG Meeting, dated January 1, 2007

NRHM and provided information on reproductive health and gender, IPC, and record keeping. The aids were developed, pre-tested, adapted, and used to make notes as well as record details collected during household visits. In addition, the ASHA Plus workers were provided with individual diaries to maintain their records. All training materials and specially prepared job aids were field tested before being provided to ASHA Plus workers. The job aids and diary are now used by the Uttarakhand Department of Health and Family Welfare with slight modifications. Table 4 presents a summary of the resource materials developed for ASHAs.

"The information, education, and communication (IEC) material (job aids) given to us proved to be very useful. We learned so much and found communities more receptive to what we had to share. The poster flag on nutrition and information on menstrual hygiene were particularly informative. We have still kept some of the learning aids and IEC booklets, even though we are no longer ASHAs but have graduated to being trainers working with other NGOs."
Geeta Kunwar, former ASHA Plus Field Supervisor

Training Phases: Each of the four phases included a training-of-trainers (ToT) and mentoring sessions, followed by the training of ASHA Plus workers.

At the state level, ITAP staff and consultants conducted a ToT for NGO workers, block medical officers in charge (MOIC), and Directorate and UKHFWS officials. At the district and block levels, ITAP organized training sessions for ASHAs and NGO staff. The training sessions provided information on myriad issues, including the program structure, medical issues, health facilities and service providers, registration, community meetings, relevant government programs like the JSY, home remedies, hygiene and sanitation, waste disposal, nutrition, child and maternal health, immunization, FP, first aid, gender, communication, counseling, sexually transmitted infections including HIV, record keeping, coordination, facilitation of meetings, and development of a village health plan.

During these trainings, the focus was to enable ASHA facilitators (as master trainers) to speak comfortably about FP/RCH issues.

A DAY IN THE LIFE OF AN ASHA PLUS WORKER

An ASHA Plus worker has a full day of household responsibilities as a mother, wife, and daughter-in-law, yet she manages to mobilize the community on health issues. She is the backbone of the health care service delivery system battling difficult terrain, poor transport and road connectivity in reaching families. She is not paid a monthly salary but compensated according to performance, based on the number of people she convinces to use essential primary health services.

A typical day in the life of a woman working as an ASHA Plus Worker starts at 4 am, before her family is up, when she begins her kitchen work and goes out to the fields to collect grass and cooking fuel. Many still use the fields for toilet as they do not have a toilet facility at home.

From 7 to 9 AM is a busy time when she feeds her children, packs them off to school and prepares food for the family, but most women end up eating leftovers themselves. This is also the time she begins her work as an ASHA Plus worker with making home visits and taking children of her community to an ANM /Anganwadi center for immunization.

Around lunch time, she cooks and cleans and feeds her children and in-laws; and in case the morning weather was unsuitable for making home visits, she does her field work now.

Her role as an ASHA Plus worker continues till the evening as she talks to families/counsels them on health services and monitors their health status such as pregnancy, ANC and PNC, while she is in the fields again for farm work, or knitting sweaters or handloom to supplement family income.

In the evening, she collects the cows/goats, cooks and feeds the family and sleeps after putting everyone else to bed. She is also aware that she may be woken-up during the night by a pregnant woman in her community who might need assistance to get to the health center for institutional delivery.

The ASHA Plus workers found time to interact with the community on institutional delivery, FP methods and immunization, in addition to their demanding schedule of chores. Despite this busy schedule, 570 women took time out for 25 days of residential training during the ASHA Plus program.

TABLE 4: A SUMMARY OF THE RESOURCE MATERIALS DEVELOPED FOR ASHA PLUS WORKERS

S. No.	Resource Material	Target Audience	Purpose
1	***Seekhein aur sikhayein:* ASHA *prashikshakon ke liye margdarkshika* (Charan 1-5)** (ToT Manuals for ASHA trainers)	Reference training manual for ASHA trainers	Training manual detailing each day's activities and training material required for each stage of ASHA training
2	**ASHA diary**	ASHA	Reference booklet for ASHAs with technical details
3	***Shareer aur swasthya ke liye khaas khaas baatein*** (Important information regarding body and health) • ***Santulit bhojan-poshan dhwaj*** (Balanced diet and nutrition flag) • **Anemia card** • ***Apne shareer ko jaano*** ('Know your body' cards) • ***Jaise jaise hum badhte hain*** ('As we grow' cards) • ***Garbhnirodhak saadhan*** - *Adhikaar ki baat, faisla karein saath* ('Contraceptive methods, informed decision-making' cards)	ASHA Community (Job Aid)	• Basic human anatomy and physiology • The ageing process and changes in human body • Basic information on anemia • Information on supplementary nutrition using vivid job aid • Information on contraceptive methods and the process of informed decision making
4	***Mahvaree hone par kya karein*** (What to do during menstruation?) • ***Mahvaree chakra*** (Menstrual cycle wheel) • ***Pattee wala saaf kapda banane ke liye kaagaz ka farma*** (Stencil to help make a sanitary napkin with a clean cloth at home) • ***Kapda pehne huye gudiya*** (Doll for the demonstration on how to use a sanitary napkin)	ASHA Community (Job Aid)	• Basic physiology of menstruation cycle depicted through a wheel • Personal hygiene during menstruation • Instructions with pictorial guide to help women make sanitary napkin with home available clean cloth • Cardboard doll to demonstrate how to use the sanitary napkin
5	***Maan aur bachche ke liye khaas khaas baatein*** (Important information for mother and children) • ***Garbhwati ki dekhbhaal*** (Care of a pregnant mother card) • ***Prasav aur khatre*** (Labour and danger signs) • ***Khushhaal aur surakshit bachpan*** (Happy and safe childhood) • ***Bachchon ki beemariyon par charcha ka parcha*** (Card to discuss common childhood illnesses)	ASHA Community (Job Aid)	• Basic concept of conception • Detection of pregnancy and registration for ANC • Components of ANC including advice on healthy behavior • Danger signs in pregnancy • High-risk pregnancy • Promoting institutional deliveries and 5 Cs for home-based deliveries • Exclusive breast feeding including importance of colostrum • Care of newborn and danger signs • PNC and danger signs • Balanced diet for mother and child • Immunization schedule • Care of a sick child in case of common childhood illnesses
6	***Dawa Peti*** (Medicine kit)	ASHA	Store medicines
7	**Weighing scale** (Spring)	ASHA	Weigh the newborn
8	**Monitoring formats** (Soft bound)	ASHA	Monthly reporting and monitoring formats
9	**ASHA Bag**	ASHA	Store the monitoring formats, medicine kit, and job aids

ASHA Plus workers being trained on usage of IPC materials

Body mapping and role plays helped them overcome their inhibitions. In the third phase of the training, a two day theater workshop was conducted with the NGO supervisors to help them understand how to use theatre and communications for delivering effective health messages. The workshop also touched on aspects of team building and leadership. A two day ToT on social marketing of sanitary napkins, emergency contraceptive pills (ECP), oral contraceptive pills (OCP), condoms and iron and folic acid (IFA) tablets was also conducted. The training demonstrated how to introduce the concept and roll-out the social marketing plan to all NGOs, coordinators, supervisors and ASHAs.

The training of ASHA Plus workers was conducted by master trainers at the block level and supported by resource persons from the state and district health departments. Guest faculty members were invited from the government and other NGOs to provide training on specific themes. The trainings were participatory, including discussions, group activities, demonstrations, and audio-visual presentations. ITAP consultants monitored all the training sessions, which included the following topics:

- **Phase 1 (6 days):** NRHM, ELCO mapping, role of ASHA, linkages with government schemes, body mapping, anatomy, changes during adolescence, menstrual cycle and menstruation, anemia, nutrition, contraception, conception and pregnancy, complications during pregnancy, immunization, breast feeding, self-awareness, effective communication, conducting group meetings, overview of training methods, introduction to ASHA Diary, record register and keeping records
- **Phase 2 (5 days):** Recap of phase 1, clean water, knowing yourself, learning empathy, fever, tuberculosis, pneumonia, worms, immunization, care during pregnancy, post natal care, JSY, health and society, nutrition, and various diseases
- **Phase 3 (5 days):** Recap of phases 1 and 2, status of women, gender sensitivity, first aid, life skills (creative thinking and

BOX 2: ELIGIBLE COUPLE (ELCO) MAPPING

Based on the need of ASHA workers in effectively planning for their coverage of communities, eligible couple (ELCO) mapping was introduced in the training curriculum (in addition to the GoI topics). An ELCO map is a graphic representation of the location of married couples in the community who are eligible for, or are potential users of, FP services. These maps supplement the detailed registers maintained by ASHA workers as information presented in a chart of map is simpler for field worker rather than similar data organized in tables or reports. Data from ELCO maps can provide a wide range of information about the FP status of a community. It also helps in planning, monitoring, and supervising the performance of an individual service provider and of the program as well. It helped the ASHA in identifying the number and location of eligible couples of reproductive age in each village and to record which contraceptive methods they are using. This allowed ASHA Plus workers to plan their strategies/interventions by not only identifying the reproductive health status of a couple but also identifying changes in contraceptive use preferences in their working area.

problem solving), HIV, AYUSH, malaria and bites, iodine and vitamin A, home-based treatment, ASHA drug kit

(2 days): Theater workshop with NGO supervisors

- **Phase 4 (5 days):** Recap of phases 1-3, pain, burns, old age, infertility, unsafe abortions, menopause, women and health, depot holding, and essential supplies

(2 days): Social marketing of sanitary napkins, ECP, OCPs, condoms and IFA tablets, skills of communication and counseling, product information, supply chain management and distribution, reporting formats and monitoring tools.

TABLE 5: ASHA PLUS TRAINING BY INTERVENTION BLOCK

District	Intervention Block	NGO	No. of ASHA Plus Workers Trained	No. of Supervisors Trained
Uttarkashi	Bhatwari	OPEN	108	9
	Purola		63	6
Pithoragarh	Munakot	KAGAS	107	7
	Munsiyari		111	6
Chamoli	Joshimath	JANDESH	80	6
	Karnaprayag	HIMAD	101	7
Total			570	41

Table 5 presents the number of ASHA Plus workers and supervisors trained in each intervention block.

A CLOSER LOOK

CREATING A CADRE OF MASTER TRAINERS IN UTTARAKHAND

The ToT did not follow the lecture approach but built itself on the approach of participation of people. The highlights of the ToTs under the ASHA Plus program were:

- **Extensive Preparation:** All phases of trainings involved in-depth preparation and building on the challenges and lessons learnt in the previous phase. During the ToT, the lead trainers met at the end of each day to review the work and plan for the next day. This has helped enormously in improving the quality of the trainings.
- **Fostering Trainee's Ownership:** During the trainings various committees were constituted in participation with the trainees who help the lead trainers in enhancing the quality of session. Four main committees were formed; one to ensure that timelines are adhered to, second to recap previous day's work, third to lead morning prayers and fourth to develop a daily bulletin of trainings. Each committee was responsible for a task every day. This exercise brought a sense of ownership among the trainees and ensured that everyone participated. Trainees exhibited a lot of creativity in undertaking these responsibilities.
- **Participatory:** The curriculum was designed with components of extensive participation. The sessions were planned with a lot of focus on group work, analytical thinking and discussion. Other tools used were role plays, exercises to develop presentation skills and demonstrations and ice breakers to bring excitement and fun. Along with this, local folk tales and case studies were used to make into relevant to the local needs of the participants. Trainees were guided by lead trainers, in small groups which improved understanding and enhanced group discussions.
- **Demonstration:** The training sessions included demonstrations for most activities which made learning interesting. Some of the most appreciated sessions were demonstration on the correct way of taking weight of a new born baby using a weighing scale; demonstration on cooking nutritious food by using regular ingredients that are easily available in the villages, and demonstrating the right way of washing hands for *'Dais'* before a delivery. Though very basic exercises each taught correct practices, while being entertaining.

Specific sessions to demonstrate use of job aids for ASHA Plus workers

were interwoven into each phase. These sessions would help ASHA Plus workers to efficiently use job aids for IPC with the communities.

- Use of films and resource persons: The training used the expertise of different people to increase the quality of sessions. Involving technical experts as resource persons brings in different perspectives and information on related areas. This helped in various ways. First, it increased the scale of information for the trainees. Second, it provided them an opportunity to interact with other players in the area and thirdly, it helped build networks and develop linkages.
  - Key experts were invited for ELCO mapping, tuberculosis program details, water and sanitation program, and state officials from UKHFWS.
  - In addition, films on related issues were screened, and followed up with discussions and analysis. One of the films screened in the second phase of the training, titled 'Hari Bhari' and directed by Shyam Benegal, portrays societal issues related to women and girl child through various characters. The trainees were able to relate well with the characters and through discussion were able to analyze the situations. Further, they were asked to take these discussions and analyzes back to their communities to discuss what best could be done to address these issues.

Master Trainers shared that the building of life skills enabled them to process information and apply it in the field.

"That I can actually communicate about women's health, being a man... unthinkable! But I am actually doing this now and I think I am doing well! I would never have imagined this a couple of months ago."

ASHA Master Trainer,
Bhatwari Block

Capacity Building and Mentoring: Following the comprehensive trainings, ASHA Plus workers assumed their place in the community with commitment, confidence, and enthusiasm. Roles were clearly assigned to them, and feedback, review, and monitoring mechanisms were explained. The NGO partners worked with them to review progress on a daily basis.

"The strength of the program was the efficient manner in which every step was carried out, from recruiting ASHA Plus workers to conducting trainings, building capacities, developing their skills to interact with communities and government offices, and reporting back to funding organizations in an organized fashion. Even two years after the program ended and transitioned into the state's own health program, the ASHAs remember us fondly, recalling their experience and learning—most of which they apply to their current work."

Laxman Singh Negi, Secretary
Jandesh, Chamoli District

ASHA Plus workers organized monthly meetings and health-related activities in villages and ANM sub-centers, as well as cluster meetings and meetings at PHCs and community health centers (CHCs). Master trainers, field facilitators, and block coordinators attended the meetings, during which village PRI members often made suggestions to NGO staff. On some occasions, officials from other departments, such as water and sanitation, also participated.

Community mobilization activities, including street plays, social audits, and health camps, were an important component of the ASHA Plus program. Street plays addressed topics such as breastfeeding and the advantages of institutional delivery. Social audits helped raise awareness about maternal and child health issues facing communities, such as the lack of waiting space for visitors, unsanitary conditions in hospitals, the need for sub-centers to provide care to pregnant women in villages, and the unavailability of female doctors in general and of any doctors at odd hours.

Project staff held village-level meetings and conducted health camps in coordination with MOICs along with the ASHA Plus workers. Health camps

included follow-up and village level meetings with ASHA Plus workers to create more awareness around RCH programs, emphasizing immunization and institutional delivery. IEC material, including posters, pamphlets, and banners, provided information for community members on the roles and responsibilities of ASHA Plus workers.

4.6 MONITORING MECHANISMS

ITAP developed regular systems at different levels to review the progress of NGOs and ASHA Plus workers.

At the community level, ELCO mapping was introduced as part of the ASHA Plus program to identify the number and location of eligible couples of reproductive age in each village and to record which contraceptive methods they are using. The ELCO maps allowed ASHA Plus workers to not only identify the reproductive health status of a couple but also track changes in contraceptive preferences.

Each ASHA Plus worker was given a register to record her activities. She then prepared a monthly report based on data recorded in her register, and submitted the report to her supervisor. Records maintained by the ASHA Plus workers included data on maternal and child health, FP, IFA consumption, de-worming, Directly Observed Therapy, Short-Course (DOTS), first aid, referrals, toilet construction, deaths in the community, and community meetings held. Monthly meetings allowed the ASHA Plus workers to review their records with supervisors. Meanwhile, most ASHAs working under the NRHM program only maintained complete records of institutional delivery and immunization in order to claim their incentive payments, with no system to track individual clients.

Reporting systems introduced included the monitoring of field visits by NGO staff. The Field Facilitator and Master Trainers held monthly cluster meetings for continued capacity building on training needs identified in the field, to review ASHA Plus workers' problems, and experience sharing. Reviews were conducted to determine retention and attrition rates and identify reasons for any personnel changes. These reviews helped verify the number of ASHAs who regularly attended meetings and made referrals.

The supervisors reviewed the ASHA Plus workers' individual reports and, after resolving inconsistencies and errors, prepared a compiled report and submitted it to the block coordinator. The supervisors and block coordinators went back to the field to validate the reports submitted by the ASHA Plus workers. A checklist was developed, and the supervisors and block coordinators trained on administering them, for the validation. In turn, the Block Coordinator further compiled reports and submitted a consolidated report of the block to the MOIC.

Monthly review meetings at the MOIC's office provided an opportunity for dialogue about the program between government health officials, ASHA Plus supervisors, and ANMs. This allowed ASHA Plus supervisors to keep themselves informed about government announcements and plans, to talk to ANMs, flag issues, and help strengthen their cooperation with ASHAs within the communities.

Half yearly district level review meetings were also conducted with participation by the CMO, ICDS and *Swajal*[5] district official with the implementing NGO. These meetings were essential for inter-sectoral convergence on issues of health like birth-death registration, immunization, access to safe drinking water, etc.

The ASHA Plus trainings conducted by ITAP and UKHFWS were evaluated as they were conducted, and ASHA Plus workers were also asked to provide feedback on the usefulness of the trainings. Other monitoring activities included review of implementation by the Technical Advisor Group (TAG) at the state level. The TAG, as a forum at the state level, was a critical link between field implementers and decision makers. Headed by the Executive Director of UKHFWS, the group included concerned officials from the GoUK, from the Department of Health and Family Welfare as well as UKHFWS, USAID, ITAP, technical experts, and NGO representatives. Besides reviewing implementation, the TAG also provided inputs for solving field level problems and approval for future project activities.

4.7 AWARDS AND RECOGNITION SYSTEM FOR ASHA PLUS WORKERS

The ASHA Plus workers were at the core of this intervention. It was essential to not only build their capacities but also empower them so that they are true ambassadors for health in their communities. To

[5] *Swajal* is the water and sanitation reform implemented in the state.

SUPPORT FOR *SAHIYYAS* IN JHARKHAND

The Government of Jharkhand identified the need to train the community health volunteers, called *sahiyyas*, on effective IPC. As part of a benchmark activity of the IFPS program, ITAP, along with the Child in Need Institute, as a local partner, trained 125 ANMs and lady health visitors (LHVs) as master trainers in IPC on RH in the Bokaro and Gumla districts of Jharkhand. Training materials, curricula, and job aids were developed through a consultative process with stakeholders, government officials, and program managers. The toolkit materials developed included a facilitator's guide and an instructional video on counseling steps in FP for the master trainers. *Sahiyyas* had an easy to carry box with contraceptive samples and leaflets for facilitation and demonstration, a reference book, and booklets with contraceptive choices for men and women. The training focused on the GATHER* approach to strengthen training and interpersonal skills. Mock training sessions with feedback from facilitators were held with the trainers.

The first ToT phase focused on IPC to help couples make positive FP choices while addressing myths and misconceptions. Participatory training included facilitation skills, management of group dynamics, brainstorming, role-play, group work, and reporting.

The second ToT phase focused on building the capacity of *sahiyyas*, ANMs, and LHVs to understand their roles as CHWs; conducting IPC with couples, women, and the community; resolving myths on FP; motivating communities to adopt FP methods; and using IPC materials and tools effectively.

* GATHER is a well-accepted approach for IPC in which the counselors are trained to greet the client (establish rapport), ask the client (gather information), tell the client (provide information), help the client (with problem solving and decision making), explain to the client (key information for the decision), and return/refer/reality check. (Rinehart, Rudy, and Drennan, 1998)

SUPPORT FOR ASHAs IN UTTAR PRADESH

Uttar Pradesh, which is India's most populous state, also has some of the country's worst health indicators. The role of ASHAs therefore becomes significant in creating awareness as well as strengthening linkages between communities and medical services. Uttar Pradesh has nearly 130,000 ASHAs working in the health system, and they provide a significant opportunity to disseminate effective messages for priority health behaviors if they are continually trained, informed, motivated, and empowered. While ASHAs received an initial training in the state, there was a need for continuous communication with and between ASHAs to continue the capacity-building process. To upgrade ASHAs' knowledge levels and give them a platform where they can air their views, share their achievements, and learn from each other, the IFPS project supported the NRHM to produce an exclusive ASHA newsletter called *Ashayein*, a 12-page quarterly. An informal needs assessment through field visits with ASHAs was followed by finalization of a framework and design for the newsletter. A core group of subject matter specialists from the Government of Uttar Pradesh, State Innovations in Family Planning Services Agency (SIFPSA), and ITAP developed the newsletter. The framework and content was pre-tested with ASHAs through individual interviews and focus groups for comprehension, retention, appeal, likeability, overall impact, and intention to respond. The newsletter was unique since it provided the ASHAs an opportunity to share their success stories with their counterparts and was a means of celebrating their accomplishments.

The CMO of each district was in-charge of distributing the newsletter to ASHAs. The first newsletter was prepared for June–September 2008. Since inception, more than 150,000 copies each of nine issues have reached ASHAs working in the state. These newsletters have been instrumental in keeping the ASHAs abreast with the latest information. As one ASHA shared in her letter:

"I am delighted to receive this newsletter and for the opportunity to write back to you. Now when I go for a meeting in my village with latest information from the newsletter, women listen to me more attentively".

ASHA in District Chandauli, Uttar Pradesh

achieve this, an identity card was issued to the ASHA Plus workers by the Block MOICs. This contributed to their empowerment and recognition.

In recognition of exemplary work of ASHA Plus workers, a yearly award mechanism was instituted. A composite objective criterion was developed based on 10 indicators developed by the NGOs in consultation with Block Coordinators.[6] Each supervisor selected one best performing ASHA Plus worker in his/ her area who was in turn eligible for a certificate and a reward sum of Rs. 1000 (USD 20). Selected ASHAs were awarded in a function chaired by senior officials of the block, including the MOIC and the Block Development Officer, with nearly 100 attendees.

4.8 RAPID ASSESSMENT OF ASHA PLUS PROGRAM

In March 2009, several stakeholders collaborated to conduct a rapid assessment of the ASHA Plus pilot program to determine whether the pilot project was beneficial. The rapid assessment comprised three teams of 3–5 people, each visiting one district. The three teams included representatives of UKHFWS, the State Health Systems Resource Center (SHSRC) (four people),[7] USAID (two people), ITAP (four people), and two consultants. During their five-day visits, the teams visited one intervention block in each district, except in Chamoli District, where they visited both the intervention blocks. The team also visited non-intervention blocks in each district, namely Dunda in Uttarkashi, Dasoli in Chamoli and Dharchula in Pithoragarh, to gauge the NRHM ASHA program implementation in similar settings.[8] The teams interviewed district and block health officials, NGO staff, ASHA and ASHA Plus workers, and beneficiaries within villages. Using interview guides, the three teams interviewed a total of 120 beneficiaries, 24 ASHA workers, six MOIC, three deputy CMOs, and three CMOs, along with the NGO staff in the selected blocks.

In each intervention block, the assessment teams collected data from the ASHAs in 3–4 villages per block. In the villages with ASHA Plus workers, all were able to produce records of their clients' use of maternal and child health services. However, the assessment team was able to obtain data from only one comparison block—Dunda, in Uttarkashi District. The other comparison sites were unable to provide any data.

Table 6 provides the details of key indicators from the intervention and comparison blocks in Uttarkashi district. The data from Bhatwari, an ASHA Plus block, and Dunda, a comparison block from the same district, show greater use of maternal and child health services in the ASHA Plus area, as indicated by the proportion of women with early registration of pregnancy, institutional delivery, registration of newborns, and the number of community meetings held. Proportion of early registration of pregnancy of pregnant women was found to be significantly higher in ASHA Plus intervention villages (79 %) when compared to the registration of pregnant women from the comparison blocks (18 %). Seven out of ten births were registered, which was significantly higher in the intervention blocks (39%). More numbers of community meetings were held in the intervention blocks than in the comparison blocks during assessment period.

4.9 RESULTS OF THE INTERVENTION

MIS information gathered through ASHAs periodically and systematically on pregnancy and other RCH related indicators for the intervention period from July 2007 to December 2008. From the MIS records, data

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[6] These indicators include distance of village from CHC, distance of village from closest motorable road, population covered by ASHA Plus worker, percentage of complete immunization, percentage of complete ANC coverage, percentage of institutional delivery, percentage of efforts in family planning, coordination and relation with ANMs, relationship with villagers and coordination with village heads. Each indicator was graded on a scale of 1 to 10 by the Block Coordinator for selecting ASHA Plus workers for reward.

[7] The SHSRC is a unit set up at the state level under the NRHM to provide technical support in its implementation.

[8] The comparison blocks were selected from the same district, with similar geographical terrain and population. Specifically, Bhatwari and Dunda had a population of 51,995 and 55,848 respectively (Census, 2001)

TABLE 6: FINDINGS OF KEY INDICATORS OF RAPID ASSESSMENT, MARCH 2009[9]

March 2008 – February 2009	UTTARKASHI	
Indicators	**Bhatwari (ASHA Plus in 4 villages)**	**Dunda (comparison block, 4 villages)**
Percentages based on recorded cases indicated below		
Early registration of pregnancy (% of registered pregnant women)	78.7***	18.3
Institutional delivery (% of total deliveries recorded in the previous year)	83.1	71.2
Weight records (% of deliveries recorded in the previous year)	86.2	NA
Birth registration (% of deliveries recorded in the previous year)	69.2***	38.5
Modern contraceptive use (% of eligible couples)	46.2	NA
Number of community meetings in a year	47	3
Average earning from JSY (Rs)	7,400	8,000
Number of cases reported		
Number of pregnant women registered	47	71
Total deliveries in the previous year	65	52
Number of beneficiaries who received the JSY money	53	58
Number of babies whose birth weight was recorded	56	NA
Number of babies who were registered	45	20
Number of eligible couples in target population	173	NA
Number of couples using modern contraceptive methods (sterilization, OCP, condoms, and IUCDs)	80	82

*** p <0.001; other values not significant

Source: ITAP, 2009. Rapid Assessment Report

were compiled for key indicators in all six ASHA Plus intervention blocks. Table 7 provides the reach of the program in terms of number of beneficiaries. During the project intervention period, the ASHA Plus workers in these blocks reached out to 7,620 pregnant women during the intervention period.

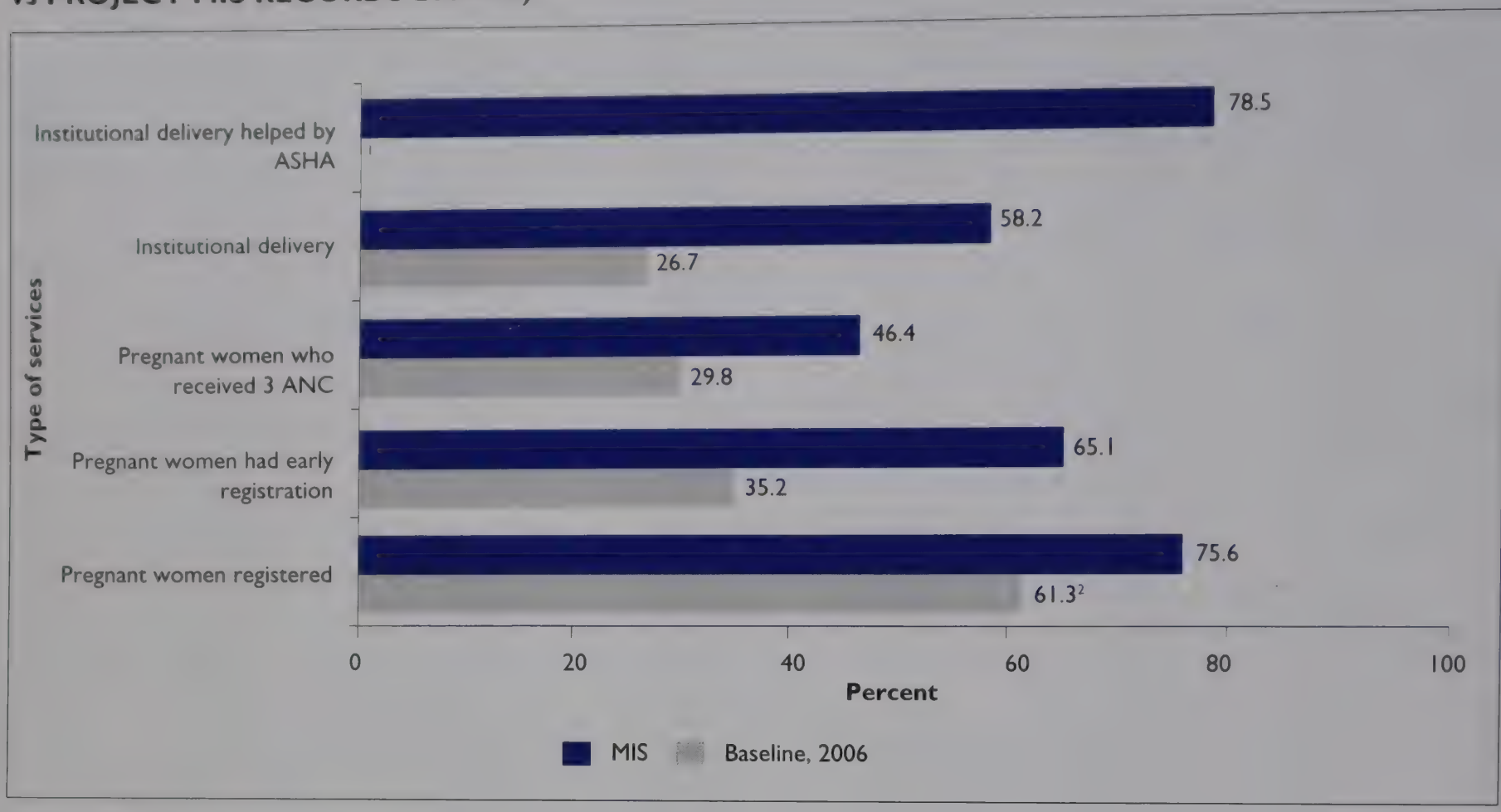
A baseline line was conducted in six pilot blocks in 2006. All the delivery related information was collected from women who delivered during two years prior to the survey in

[9] For details on other blocks, refer to Annex B

TABLE 7: NUMBER OF BENEFICIARIES REACHED THROUGH ASHA PLUS INTERVENTION IN SIX BLOCKS (JUL 2007 – DEC 2008)

Total population in 6 intervention blocks		256,415
Expected number of pregnant women		10,173
S no.	**Types of services provided**	**Number of beneficiaries**
1	Pregnancy registration	7,690
2	Received 3 ANC checkups	4,725
3	Total deliveries during this period	6,920
4	Institutional deliveries during this period	4,025
5	Received PNC checkups	4,293
6	Children received BCG	6,336
7	Children received complete vaccination	6,813

FIGURE 3: TRENDS IN KEY INDICATORS IN ASHA PLUS INTERVENTION BOCKS (BASELINE 2006 vs PROJECT MIS RECORDS 2007-08)



[1]: Not applicable

[2]: Any visit made to avail ANC checkups

the baseline. Comparison has been made between the findings from baseline with the MIS results on key indicators to show the progress of the intervention.

Early registration of pregnancy is important because it identifies women in need of ANC services. As shown in Figure 3, the early registration of pregnancy has increased from nearly 35 percent in 2006 to 49 percent during the project period.[10]

At the time of baseline, only 30 percent of pregnant women had availed three ANCs which increased to 59 percent during the intervention period. The percentage of births delivered in a health facility has increased from 27 percent in baseline (among births in the three years prior to the survey) to 58 percent during the intervention period (from July 2007 to Dec, 2008). Nearly, four out of five institutional deliveries were helped by ASHAs in the intervention blocks during the pilot.

[10] Refer Annexure A for block wise data

Chapter 5

FINANCIAL ALLOCATION AND EXPENDITURE THROUGH USAID FUNDS

USAID invested USD 1,348,000 in this project through benchmarks. Of this, the total initiation costs, including development of the ASHA Plus model, project start-up, and development of monitoring systems totaled USD 612,000. Another USD 113,000 was allocated for capacity building. The actual implementation costs, which included NGO implementation costs, from April 2007–March 2009 totaled USD 623,000.

Chapter 6

MAIN ACHIEVEMENTS

The ASHA Plus program, which was tailored for the unique context facing CHWs in Uttarakhand, created a flexible, multi-layered system to improve health outcomes through community engagement. This system included benefits for the community and also for the ASHA Plus workers.

Enabling communities to access health services: By offering far-flung communities the opportunity for regular contact with the health system, the ASHA Plus program resulted in better service utilization. Health officials reported that in the ASHA Plus intervention blocks, service utilization improved and ASHA Plus workers were more motivated and efficient as they had support of the NGO staff. Definite improvement was seen in the distant and underserved villages in the areas of early registration of pregnancy, antenatal care, and institutional delivery, as shown in the rapid assessment results detailed above.

One core component of the ASHA Plus program was reaching underserved villages. Distant habitations precariously perched atop hilltops where few doctors practice led to communities completely bereft of medical care, advice, and counseling. ASHA Plus workers delivered preventive and promotive services to people in inaccessible zones. Timely referral by ASHA Plus workers, with their regular interaction and resultant linkages with health service delivery points, proved to be a life-saving intervention in many instances.

With the support of NGO staff and ASHA Plus workers, communities also demanded services and regular visits by health workers to their villages. NGOs supported ANMs in reaching these inaccessible villages on regular basis. This encouraging trend of health systems responding to community needs highlights the power of community engagement.

Using local knowledge to build programs: The constant supervision and monitoring provided by a local NGO that was familiar with the terrain, people, and functioning of the health department augured well for the program. The NGOs' efforts improved the recruitment of ASHA Plus workers and ensured that they were well trained, supervised, monitored, and mentored. These successful practices were adopted by the GoUK during the scale-up phase when the NGOs' responsibilities were transferred to the State ASHA Resource Center (SARC) and District ASHA Resource Center (DARC) for state, district, block, and sub-block level ASHA support system (as detailed in the next section).

"The NGO was like a pivot around which all activities of the ASHA Plus program were planned. The program had a "plus" element because of the results it delivered, ensuring that the needs of the community were met promptly and all bottlenecks resolved."

Laxman Singh Negi, Secretary, JANDESH

The ASHA Plus program has emphasized the importance of working with ANMs/AWWs to ensure better service delivery. ANMs have been, in many cases, mentors and guides for ASHA Plus workers. They view ASHAs as support at the village level, helping them deliver better results in immunization coverage, institutional delivery, sterilizations, and outreach activities. ASHA Plus workers can coordinate with ANMs/AWWs and use Village Health and Nutrition Days and monthly meetings to improve convergence and coordination amongst other departments.

Building capacity as a cornerstone: A unique element of the program was that it took a 360-degree approach, not only building the capacities of the ASHA Plus worker but also creating awareness in the community as well as sensitizing and training medical

SUCCESS STORIES: SMALL VICTORIES, BIG GAINS FOR THE COMMUNITY

- In Badgaon village, where there were as many households atop a hill as at the base, it was difficult for one ASHA Plus worker to serve residents. The community's request for two ASHA Plus workers was considered to enable the program to serve the population better.
- In another case, residents of the remote village of Dumak Kalgoth battled broken paths and no roads, walking 28 kilometers to attend a health camp. No ANM, ASHA, or health worker visited the village. The NGO overseeing the area raised the issue with the MOIC and CMO, who assigned a separate ANM for the area and also wrote to the district administration to request improved road connectivity.
- In Karnaprayag CHC, a nurse demanded money to conduct an institutional delivery. The local ASHA Plus workers registered a complaint with the CMO through the NGO overseeing the area. The nurse was transferred. The nurse who replaced her went an extra mile to be helpful to people visiting the healthcare facility.
- In Silangi village, the designated ANM rarely showed up. This was discussed by ASHA Plus members at the monthly cluster meeting, after which three ASHA Plus members went to the CMO with a letter. Within a month, the ANM started making regular visits.
- Financial incentives to ASHAs have to be cleared by the ANM. In many cases where ASHA Plus workers referred men for no-scalpel vasectomies, the ANM kept more than 50 percent of the money with her. Most ASHA Plus workers chose not to complain since it would jeopardize their relationship with the ANM. However, ASHA Plus supervisors and a team of ASHA Plus workers addressed the issue. Some ANMs refunded the money and a few apologized. Initially, the ASHA incentives were paid in cash through the MOIC and local ANMs but considering this case, the DARCs were instructed by UKHFWS to open zero balance savings bank accounts for each ASHA. Now, performance-based reimbursements are paid directly to the account payee in the form of checks.

Recounted by Hema Bhatt,
Former Block Coordinator,
ASHA Plus, Joshimath Block

officers within the government health system. The training provided to existing health officials as part of the ASHA Plus program was viewed as extremely beneficial. Many officials expressed the need for refresher training for themselves and new training for officers who had just joined the system and missed the earlier round of training and capacity building.

"The three-day residential training in Dehradun at the start of the project oriented us to the overall design of the ASHA Plus program. It was useful, and we got a lot to learn. We wish such trainings were part of our annual plan, vis-a-vis other programs too."

Dr AK Singh,
Chief Medical Officer, Department of Health and Family Welfare, Chamoli

Building on what is available:
The introduction of new tools, such as the ELCO map, has been helpful in providing accurate data to support program implementation and highlighting areas where further data collection is needed. The ELCO map was useful in identifying the actual number of couples in the age group of 15–49 eligible for FP and the change in their contraception preferences. The GoI modules were adapted and improvised to design new job aids for enhancing ASHA Plus workers' communication with the families and also to build their capacities. These job aids and the ASHA Plus diary also assisted the ASHA Plus workers in accurately sharing health information and maintaining high-quality records during their busy schedules.

Using flexible remuneration:
The program also offered flexible remuneration based on performance and results. While compensation was not the sole motivator for the proactive role played by ASHA Plus workers in the community, the expanded approach towards performance-based payments, with a greater number of services compensated, was well received.

Although ASHA Plus supervisors and block coordinators were paid fairly and the program offered an opportunity for income generation that was unprecedented for most women in rural areas, the underlying sentiment was that of volunteering for the greater interest of the community. Highly motivated and enthusiastic, the efforts of the ASHA Plus workers and NGO staff helped them establish trustworthy relationships with the communities. Attrition rates were low, and the workers demonstrated an eagerness to learn more and assume greater responsibility.

"In our block, the attrition rates [of ASHAs] were low. There were only three names that had to be pulled out of the roster because two died and one got married and moved to another district. All three were replaced."

Geeta Kanwar,
Former Block Coordinator, Joshimath

The program did not neglect the challenge of building community support among men. Many supervisors in the ASHA Plus program reached out to men who were resistant to allowing their wives, when selected as ASHA Plus workers, to attend meetings and trainings.

As leaders in their community, ASHA Plus workers were true examples of empowered women

BOX 3: A UNIQUE SISTERHOOD COMES TO SITA'S RESCUE

Sita, an ASHA Plus worker in Joshimath district in Uttarakhand state, lost her husband soon after marriage. Upon attending the ASHA Plus residential training, her father-in-law rebuked her for venturing out of the house, and attempted to disinherit her from family property. When Sita shared this with the other ASHA Plus workers, they took her case to the village *panchayat*. As a result, a room was allotted to Sita in her in-laws' house with all domestic rights assured. Today, Sita is re-married and settled in another village. She credits ASHA Plus workers for giving her the courage to fight for her rights.

ASHA PLUS SUPERVISORS INSPIRE A NEW CADRE OF ASHA FACILITATORS

Within the ASHA Plus program, the role of the ASHA supervisor was seen as a major success. Using it as a model, the state health department introduced the ASHA facilitator within their cadre. The facilitators were chosen from the ASHAs, in consultation with the MOIC. Their job is to visit ASHAs, collect and check their records, and fill in reporting forms—almost the same as it was for supervisors during the ASHA Plus pilot.

The facilitators follow a monthly plan while reporting back to the block coordinator. They are each paid up to Rs. 5000 (USD 100) and expected to visit 20 ASHAs each month, with a compensation of Rs. 250 (USD 5) for each visit. In areas with low numbers of households, facilitators are expected to make more than one visit to the same households and conduct follow-up. Monitoring is strict, with each missed visit resulting in a deduction of Rs. 250 from the remuneration package. Currently, there are 11,086 ASHAs and 550 facilitators in the state—one facilitator for every 20 ASHAs serving the most difficult areas.

Building capacities that last: Supervisors served as the backbone of the program, working alongside the ASHA Plus workers in close contact with communities, thereby helping government health departments improve the utilization of services in other national programs (such as Pulse Polio), which needed area-based supervision. Just as many of the ASHA Plus workers have transitioned into the GoUK's expanded ASHA program, as also some supervisors have been inducted into the government health system.

Empowering women as change agents in their communities: The training received during the ASHA Plus program opened many doors for ASHA Plus workers. The life skills education incorporated in the training helped them gain confidence in their abilities, develop leadership qualities, and see themselves as influencers within their community. A few ASHA Plus workers were nominated by the village/*Panchayat* for the position of village *pradhan* (village head). Once they landed the coveted position, they demonstrated excellent communication, management, organizational, and networking skills. While some of this was a result of their innate abilities, much of the direction and motivation came from the ASHA Plus program.

"In some villages, ASHA Plus workers motivated conservative men who refused condom use, thinking family planning was the sole preserve of the woman, to actually go in for vasectomy."

Hema Bhatt, Former Block Coordinator under ASHA Plus, representing HIMAD NGO

Using supportive supervision as a monitoring approach: The well-coordinated and well-managed recording, monitoring, and evaluation systems have been another key factor in the program's positive results.

"We are so satisfied with the reporting system followed in the ASHA Plus program that we aim to replicate the process for other ASHAs across the district."

CMO, Pithoragarh

As one of the monitoring mechanisms in place, household surveys were conducted on a regular basis to track the families' health profiles. Every month, five households were visited by supervisors and an ASHA Plus worker. They assessed delivery cases and monitored all other parameters. The ASHA Plus worker kept a note of which homes/families showed reluctance and sought guidance on reaching them through another intervention at a later date.

The ASHA Plus program strengthened the capacity of the workers themselves as well as the agencies and staff that provided monitoring, supervision, and complementary health services. Women acquired leadership positions, and the workers demonstrated low attrition rates along with a high spirit of volunteerism.

6.1 CHALLENGES AND LESSONS LEARNED

In the upper Himalayan regions, the availability of medical services is erratic. In the absence of allopathic doctors, traditional healers and quacks thrived, often at the cost of people's physical and financial health. The ASHA Plus program generated increased demand, but this became a renewed challenge, especially since the uptake of PNC and FP was still low in implementation blocks. To address this, some medical staff was repositioned and services improved, with ASHA Plus workers making continued efforts to improve utilization of all health services. Moving forward, continued training on healthcare skills will enhance the ASHAs' ability to serve their communities. Providing computer training to ASHAs and building their knowledge on related issues such as education, environment, livelihood, research, and communication would add value and depth to the quality of their interactions with the community.

Community awareness regarding existing government health schemes: Topographical challenges, especially during monsoons and winter months, compounded issues of transport and communication. People were often stranded for days at end, unable to access timely medical help. Also, because of these physical barriers, many people ignored health issues, postponed treatment, or utilized locally available options such as home delivery. Not all village-level health sub-centers were operational.

To address this, ASHA Plus workers increased communities' awareness of available health services. For example, many households were unaware that the government offered reimbursement of transportation expenses to pregnant women who delivered in facilities. ASHA Plus workers also informed communities of toll-free phone numbers to receive information about ambulance services, mobile health vans, and health camps. The ASHA Plus workers also engaged communities in developing village

health plans and organizing regular trainings.

Relationship between ASHA and ANMs: In many places, the ASHA Plus workers became essentially "assistants" to ANMs, often intimidated by the latter's sway in the community and the fact that an ANM's signature and stamp was needed on the ASHA Plus worker's performance review to enable her to claim compensation. This led to exploitation and harassment in some cases, where the ANM demanded a "kickback" from the performance-based payment and refused to stamp the performance review if the ASHA Plus worker was noncompliant.

To resolve this, training and counseling of both ASHAs and ANMs became an ongoing exercise, and monitoring mechanisms were made more transparent and "harassment-proof." For example, for every delivery in the government facility, ASHA Plus workers received a direct payment of Rs. 600 (USD 12), which in a single stroke eliminated the role of "middlemen." Also, monthly review meetings in MOICs' offices were an excellent way of creating transparency, allowing everyone to air their views and concerns. In places where ASHAs and ANMs worked well together, results in the community on health indicators were notably better as reported in feedback from MOIC, CMOs, and the implementing NGOs.

Continuous supplies: As the program achieved scale-up, some challenges remained. In some cases, delays and a lack of guidelines impeded progress and results. Health officials recommended the creation of an emergency fund for exigencies or unexpected circumstances. In some cases, shortages of supplies such as IFA tablets, bandages, and ASHA kits not supplied by the GoUK diluted the overall efficiency of ASHA Plus workers.

Engaging and re-engaging with stakeholders: While engagement with and building support from the community was a major achievement for the ASHA Plus program, this area could be strengthened even further. In many places, PRI members may be newly elected and have little or no knowledge about the roles and responsibilities of the ASHA. Therefore, they could not guide the community accordingly or press for their greater cooperation. In some places, the PRI and ASHA Plus workers have worked in isolation, without the other being really aware of their role, impact, and challenges.

Linkages in the health systems: As the program scaled up, it would be important to create avenues for greater interaction through coordination meetings to bridge gaps in knowledge and build support for complementary roles. ASHAs and DARCs should work closely with MOIC, keeping them informed of activities and plans. Efforts to further mainstream ASHAs into the NRHM structure would help, with better coordination with MOIC in the form of regular meetings with government health officials and monitoring visits.

Chapter 7

GOING TO SCALE

Based on the performance results identified in the rapid assessment, the GoUK decided to scale up the ASHA Plus program to the entire state, using its own funds through the NRHM Program Implementation Plan. After the ASHA Plus program ended in early 2009, the GoUK adapted many of its components for scale-up, devising state, district, and block-level structures to support and strengthen the ASHA program that together are known as the ASHA Support System. A transition plan was developed for the existing ASHA Plus NGOs as the state implemented the scale up plan.[11]

7.1 STRUCTURE OF ASHA SUPPORT SYSTEM

7.1.1 State ASHA Resource Center

As per GoI guidelines, the State ASHA Resource Centers were initially planned to be established within the SHSRC. However, the state decided to involve NGOs at the state as well as district levels.

A SARC was created to provide overall guidance and technical leadership to the ASHA Program, as ITAP had during the pilot phase. The Himalayan Institute Hospital Trust (HIHT) was designated as the SARC. It already existed as the technical agency that provided inputs and supportive mechanisms to the ASHAs under NRHM with a core focus on human resources and IPC skills. Specific functions of the SARC include capacity building through a cascade training model; establishment of MIS at all levels; community mobilization through BCC, including ASHA job aids; creation of a reward system for ASHAs; social marketing of contraceptives and other health products by ASHAs; monitoring and supervision, documentation; provision of opportunities for linkages and networking; and the formation of a grievance redressal cell for ASHAs.

According to the GoI guidelines, the SARC in Uttarakhand was initially staffed by two people, a project manager and a data assistant. The project manager is responsible for skills building, monitoring, and networking, while the data assistant collects, compiles, and analyzes the data that are generated at district level. As part of program scale-up, this team was further strengthened by hiring two regional coordinators[12] to support the manager in strengthening the district centers, with the responsibility for Garhwal (seven districts) and Kumaon (six districts), respectively.

7.1.2 District ASHA Resource Center

At the district level GoI accredited mother NGOs (MNGOs) were selected to serve as DARCs, following the model of the NGOs that had managed the program at the block level during the pilot. District Health Societies contracted MNGOs by providing an additional budget for them, with the purpose of mentoring and providing technical support and training to ASHAs. NRHM funds were allocated to the MNGOs to increase community participation and mobilize communities towards health-seeking behaviors. These DARCs consisted of a community mobilizer and a data assistant.

As part of the scale-up process, the state proposed to have one Block Coordinator for every two blocks and one ASHA Facilitator for every 10–12 ASHAs; but due to NRHM funding limitations, the facilitators were ultimately responsible for 20 ASHAs each. ASHA facilitators serve the role fulfilled by ASHA Plus supervisors and are responsible for supportive supervision and training of ASHAs. They organize monthly sector meetings for the ASHAs and travel regularly to communities throughout the district.

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[11] During the transition period of three months in 2009, the staffing pattern and activities remained the same for the first month. For the second and third months, the number of supervisors was decreased as they evolved into ASHA Facilitators. In the transitional period, each ASHA facilitator monitored and mentored two clusters of ASHAs (approximately 20 ASHAs). For the sake of convenience and continuity, the ASHA facilitator continued to conduct cluster meetings at the same venues and dates as was being done under the ASHA Plus program. The block coordinators supervised the work of the ASHA facilitators and ASHAs through field visits, attended cluster meetings in the block once every two months, and made visits to the villages.

[12] The regional coordinators were recruited initially for a year, but were discontinued due to funding limitations.

7.1.3 ASHA Mentoring Group

With more than 9,500 trained ASHAs working in the state of Uttarakhand, the GoUK also decided to develop a monitoring mechanism to guide, evaluate, and provide refresher training for the ASHAs, following the model that had been developed during the ASHA Plus pilot. In 2009, the NRHM conceptualized a mentoring group that would guide and oversee the implementation of the ASHA component within the healthcare system.

Subsequently, the State ASHA Mentoring Group was charged with providing advisory support in matters related to policy, operationalization, and capacity building. Members include NRHM and state health officials and technical advisors. The group's role is to facilitate the ASHA training process in the state, provide strategic guidelines and recommend areas of concern to be addressed, and hold quarterly meetings to share findings, innovations, and constraints faced in program implementation.

7.2 TRANSITIONING AND TRAINING

To ensure a seamless continuation of activities after the pilot phase of the ASHA Plus workers, ITAP trained ANMs, PHC medical officers, and SARC and DARC staff on components of the ASHA Plus program implementation, such as additional compensation, MIS, and ELCO mapping and village-level planning for ASHAs. Next, the SARC and DARC staff were trained in supportive supervision, cluster meetings, and prompt payments.

UKHFWS contracted an agency to design a training curriculum for institutional strengthening of the SARC and DARCs. They conducted a training needs assessment to determine the technical and managerial skills and training needed by SARC and DARC staff. Based on the identified gaps, a training plan for the staff was developed, with clearly defined indicators for measuring training effectiveness along with a monitoring plan. Next, they prepared and pre-tested training modules to build the capacity of staff throughout the ASHA Support System, the State Program Management Unit (SPMU) and District Program Management Unit (DPMU). Because the SARC and DARCs work in close collaboration with the SPMU and DPMU, the institutional strengthening was a collective effort to train all stakeholders involved with the ASHA program, whether from the government or NGOs.

As a first step in capacity building, existing and newly recruited SARC staff were trained on technical and managerial roles, as well as on how to provide supportive supervision. Initially, combined ToTs were held to orient and develop the skills of SARC and DARC functionaries, including CMOs, who sign the memorandum of understanding contracting MNGOs to serve as DARCs in their district.

The SARC is responsible for monitoring the quality of trainings at all levels. It follows a cascade training model, conducting ToTs for DARC staff, who in turn train ASHA facilitators. These ASHA Facilitators then train the ASHAs. These trainings are monitored through at least one visit to each district by representatives of the SHSRC, SARC, and ITAP. To ensure quality, training effectiveness is measured and documented through at least one site visit by SARC and DARC staff following the training of ASHA support system staff at the DPMU. An assessment of the ASHA Support System in Uttarakhand conducted in 2011 indicated that nearly 62 percent of ASHAs reported completing the training up to Module 7 (training modules 1–7). The training programs were found effective primarily because of the use of audio-visual kits. ASHAs reported

receiving maximum support from ASHA facilitators during community interaction and in filling reporting formats and diaries (95.3%), as compared with support received from ANMs (93.8%), AWWs (58.6%), doctors (50.8%), husbands (22.7%), *Pradhan* (20.3%), block coordinators (2.3%), and family members (2.3%).

"The 4–5 trainings we received helped us structure our plan and community mobilization strategy. Each block now has its own coordinator. As we go forward, it would help to know what the other districts are doing so that we can learn from their experience and add value to what we offer and how we run the DARC."

Kunti Rawat, DARC, Community Mobilizer, Gairsain

"ASHA Plus had good liaising, networking, visibility, and goodwill. The DARC should be modeled on the same lines, especially if it aspires to have better coordination and convergence with other government departments."

Dr. AK Singh, CMO, Department of Medical Health and Family Welfare, Chamoli District

7.3 INFORMATION AND MONITORING SYSTEMS

The MIS adopted during scale-up also follows the model of the ASHA Plus program, with records and reports collected by the ASHAs themselves and reviewed and aggregated as they pass through subsequently higher levels of the system. From ASHAs, the data are collated in turn by ASHA Facilitators, Block Coordinators, and Community Mobilizers at DARCs and then reviewed by a Data Assistant before being sent to the Regional Coordinators at the SARC. This provides various opportunities to discuss and review performance.

Quarterly meetings, in addition to quarterly reports, have been instituted between the SARC and UKHFWS. Field visits by the community mobilizers and regional coordinators to monitor working of ASHA workers are also mandated to be conducted regularly.

The State ASHA Mentoring Group provided support for active problem solving of challenges faced in implementation of the support system.

Chapter 8

THE WAY FORWARD

The ASHA Plus program was a carefully designed initiative that addressed a unique set of barriers to health services in a locally relevant, flexible way. In less than two years of implementation, it demonstrated on-the-ground results, with improvements in key reproductive health indicators in the project villages. The program results highlighted the need for a "Plus" strategy that could add new elements and a more focused approach to existing government interventions planned for the country.

The impact of the ASHA Plus program could be seen in the hilly, difficult-to-navigate areas of the state, where a more dedicated, energized, and trained workforce was activated.

Thanks to its distinctive features, the program left a strong imprint in the minds of not just the communities where it was implemented but also of the leaders in government health departments, who even after two years could recall its "infectious energy." The fair and unbiased selection of ASHA Plus workers combined with their high motivation levels and quality of training not only improved community health outcomes but also increased the amount of feedback on the program itself, which allowed for rapid introduction of new or revised components when needed. Bottlenecks were identified and solutions sought through a consultative process.

In addition to monitoring and engaging with the community, the cadre of ASHA Plus supervisors also contributed to greater accountability. The supervisor model has been recognized as a best practice and has been adopted by the state government in the form of ASHA facilitators who currently monitor the work of 20 ASHAs. The program benefited from high visibility and goodwill among the state health department and UKHFWS. In most cases, the ASHA Plus worker enjoyed good working relationships with the ANMs and medical officers, which improved the smooth implementation of all health and related activities.

An ASHA Plus worker counsels a new mother post delivery

The ASHA Plus program, as in its planning and implementation phase, had its exit strategy carefully planned. With some of its successful features incorporated in the state's existing ASHA program, the program also provided inputs in training functionaries of the SARC and DARCs. Going forward, Uttarakhand can serve as a case study that shows how difficult terrain, an unfriendly climate, and erratic availability of healthcare services can be overcome by a committed government. This program demonstrates how a collaborative effort of government and NGOs helped strengthen an existing intervention—ASHAs working under the NRHM—with additional elements of ASHA Plus to bring positive change.

ANNEXURES

Annex A

PERFORMANCE OF ASHA PLUS IN SIX BLOCKS OF UTTARAKHAND, 2006-2008

Blocks	Bhatwari		Purola		Munakot		Munsiyari		Joshimath		Karnaprayag	
Indicators	Baseline, 2006	MIS	Baseline, 2006	MIS	Baseline, 2006	MIS	Baseline, 2006	MIS	Baseline, 2006	MIS	Baseline, 2006	MIS
Women registered for early pregnancy (%)	51.6	61.9***	50.2	67.3***	40.2	78.9***	17.6	68.7***	58.4	59.2	25.5	47.4***
Women received at least three or more ANCs (%)	39.8	35.5	34.5	53.8***	35.2	46.1***	10.1	43.7***	37.4	61.1***	21.9	51.9***
Institutional Delivery (%)	21.4	61.5***	30.9	78.2***	40.4	65.9***	8.4	32.3***	27.2	54.3***	28.3	56.8***
Number of currently married women (Baseline 2006)	1102		1175		1141		1124		1080		1126	
Expected number of pregnant women@		2373		1241		2101		2124		1135		1200
No. of (pregnant) women who responded to ANC questions and institutional delivery (Baseline)	242		299		253		260		181		247	
No. of women for early registration	216	1422	257	887	228	1635	215	1643	164	933	201	1170

Notes:@- *Expected number of pregnant women is calculated as Total population*CBR*1.15/1000 [http://www.who.int/maternal_child_adolescent/documents/keysteps.pdf]*

MIS period – July 2007 to Dec, 2008

**** p < 0.001; others not significant*

ANNEX B

FINDINGS OF KEY INDICATORS OF RAPID ASSESSMENT FOR CHAMOLI AND PITHORAGARH

Indicators	CHAMOLI		PITHORAGARH
	Joshimath (ASHA Plus in 2 villages and 1 urban area)	Karnaprayag (ASHA Plus in 3 villages)	Munakot (ASHA Plus in 4 villages)
Percentages based on recorded cases indicated below			
Early registration of pregnancy (% of registered pregnant women)	74.3	81.3	45.8
Institutional delivery (% of total deliveries recorded in the previous year)	74.4	89.2	93.1
Weight records (% of deliveries recorded in the previous year)	87.2	97.3	31.0
Birth registration (% of deliveries recorded in the previous year)	51.3	91.9	41.4
Modern contraceptive use (% of eligible couples)	100.0	66.2	42.8
Number of community meetings in a year	7	27	72
Average earning from JSY (Rs)	2,250	4,650	3,300
Number of cases reported			
Number of pregnant women registered	35	32	48
Total deliveries in the previous year	39	37	29
Number of beneficiaries who received the JSY money	23	33	27
Number of babies whose birth weight was recorded	34	36	9
Number of babies who were registered	20	34	12
Number of eligible couples in target population	78	74	201
Number of couples using contraceptive methods (sterilization, OCP, condoms, and IUCDs)	78	49	86

REFERENCES

PUBLISHED

Bajpai, N., and R.H. Dholakia. 2011. *Improving the Performance of Accredited Social Health Activists in India.* New York: Columbia University.

Constella Futures. 2006. Ideas, *Insights and Innovations: Achievements and Lessons Learned from the Innovations in Family Planning Services (IFPS) Project,* 1992–2004. New Delhi: Constella Futures.

International Institute for Population Sciences (IIPS) and Macro International. 2007. *National Family Health Survey (NFHS-3),* 2005–06: India: Volume I. Mumbai: IIPS.

International Institute for Population Sciences (IIPS), 2006. *District Level Household and Facility Survey (DLHS-2),* 2002-04: India. Mumbai: IIPS.

Lehmann, U., and D. Sanders. 2007. *Community Health Workers: What Do We Know About Them?* The State of the Evidence on Programmes, Activities, Costs, and Impact on Health Outcomes of Using Community Health Workers. Geneva: World Health Organization.

Management Sciences for Health. 1992. *Using Maps to Improve Delivery.* The Manager. Vol 1, No.5, pp 1-16. Boston.

Management Sciences for Health. December 2004. *Rural Expansion of Afghanistan's Community-Based Healthcare Project (REACH): Training Guide for Community Mapping.* Boston.

Maru, RM. 1983. *The Community Health Volunteer Scheme in India: An Evaluation.* Social Science and Medicine. 17 (19). 1477-1483.

Office of the Registrar General and Census Commissioner. 2001. Provisional Population Totals Paper 1 of 2001 India Series 1. India: Office of the Registrar General & Census Commissioner.

Registrar General, India. 2006. Sample Registration System, SRS Bulletin, April, 2006.

Rinehart, W., Rudy, S., and Drennan, M. 1998. *GATHER Guide to Counseling. Population Reports, Series J,* No. 48. Baltimore: Johns Hopkins University School of Public Health, Population Information Program.

The United Nations Children's Fund. 2004. *What Works for Children in South Asia: Community Health Workers.* UNICEF Regional Office for South Asia.

World Health Organization. 2006. *The World Health Report 2006: Working Together for Health.* Geneva: World Health Organization.

UNPUBLISHED

ITAP. 2006. *Block Level Baseline Survey: Six blocks Uttarakhand.* Gurgaon: Constella Futures.

ITAP. 2008. *Project MIS: ASHA Plus.* Gurgaon: Futures Group.

ITAP. 2009. *Rapid Assessment of ASHA Plus Intervention Blocks Uttarakhand.* Gurgaon: Futures Group.

ITAP. 2011. *Assessment of ASHA Support System Uttarakhand.* Gurgaon: Futures Group.

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